MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Edmund P. Koop

Director, Program Policy Division
Bureau of Medicaid Policy and Actuarial Services

Project Number:	0432-NF	**Comments Due:**	November 15, 2004	**Proposed Effective Date:**	January 1, 2005

Mail Comments to: Denise Morrow
Bureau of Medicaid Policy & Actuarial Services
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Telephone Number: (517) 241-1013

Fax Number: (517) 335-5136
E-mail Address: morrowd@michigan.gov

Policy Subject: Revised Nursing Facility Reimbursement Chapter (Chapter VII); Nurse Aide Training and Competency Evaluation Program CNA Reimbursement Form; Rate Calculation

Affected Programs: Medicaid

Distribution: Nursing Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally Ill (Provider Type 72)

Policy Summary: The purpose of this bulletin is to provide nursing facilities with a revised Medicaid Nursing Facilities Reimbursement Chapter (Chapter VII) in the Michigan Medicaid Provider Manual. The chapter has been updated and revised to incorporate previously published policy and to clarify existing policy.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Nursing Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally Ill (Provider Type 72)

Issued: December 1, 2004 (proposed)

Subject: Revised Nursing Facility Chapter VII (Reimbursement);
Nurse Aide Training and Competency Evaluation Program
CNA Reimbursement Form
Rate Calculation

Effective: January 1, 2005 (proposed)

Programs Affected: Medicaid

The purpose of this bulletin is to provide nursing facilities with a revised Medicaid Nursing Facilities Reimbursement Chapter (Chapter VII). The chapter has been updated and revised to incorporate previously published policy and to clarify existing policy. Notable changes to policy are listed below.

Cost reports covering cost report periods ending in calendar year 2004 must use cost allocation policies and practices in effect prior to the effective date of this bulletin. Cost reports covering cost report periods ending in calendar year 2005 and beyond must use cost allocation policies and practices as outlined in this chapter.

Chapter VII Changes, Updates, and Revisions

Section 2

- Defines situations where the State Medicaid Agency (SMA) must be notified, i.e., ownership changes, termination/closure.

- Defines the circumstances under which the SMA will recognize a sale between related parties and how reimbursement will be determined.

Section 3

- Expands the definition section of the chapter.

Section 4

- Clarifies the exceptions to cost reporting requirements for certain types of providers.
- Clarifies cost reporting requirements for new owners and new facilities.
- Outlines cost reporting requirements for home offices and related parties.
- Specifies the circumstances under which a nursing facility may file a cost report under protest.

Section 5

- Clarifies when a provider may file a Plant Cost Certification and outlines the determination process.

Section 6

- Clarifies audit purpose.
- Clarifies audit process.

Section 7

- Outlines the Cost Report Reimbursement Settlement process.
- Identifies withholding of reimbursement where participation ends prior to cost reporting period end.

Section 8

- Removes appraiser pre-approval.
- Clarifies allowable attorney and legal fees, specifically related to regulatory actions.
- Establishes policy for pass-through leases for electronic equipment and vehicles.
- Specifies that Lobbying and Political Activities and Maintenance of Effort Contributions are not allowable costs.
- Establishes policy for home office compensation.
- Clarifies policy for owner/administrator compensation.

Section 9

- Revises occupancy calculation and leave day cost reporting.
- Clarifies depreciation.
- Clarifies cost allocation policy.
- Clarifies policy regarding allocation of space rental costs.
- Specifies allowable costs of day care for facility employee dependents.
- Expands and clarifies Medicaid policy regarding reimbursement for Nurse Aide Training and Competency Evaluation Programs; specifically adds coverage for nurse aide registry renewal, increases the reimbursement limit for training costs, addresses waivers to training lockouts, and specifies that nurse aide training and testing costs are not routine.
- Specifies a maximum time period for which nursing facility beds may be designated as non-available.

Section 10

- Outlines Deficit Reduction Act of 1984 (DEFRA) reimbursement.
- Clarifies and specifies the rate determination process for routine nursing facility services and specialized services (i.e., ventilator dependent care units).
- Incorporates all policy related to the Nursing Facility Quality Assurance Assessment Program (QAAP).
- Incorporates into the per diem rate Quality Assurance Assessment amounts.
- Clarifies HLTCU Variable Cost Component effective date.
- Defines Medicaid payment for Rate Relief purposes.

Section 11

- Clarifies the informal appeal process.

Section 12

- Clarifies the Medicaid Interim Payment program (MIP).

Removals and Eliminations

- Removes the option for an expedited appeal.
- The emergency interim rate relief option has been eliminated.
- Removes the Quality of Care Incentive Component, as this program no longer exists.
- Chapter VIIA. This chapter outlining the Medicaid reimbursement methodology for Alternative Intermediate Services for the Mentally Retarded (AIS/MR) homes has been eliminated as there are no longer any of these homes in the state.

Appendices

- Appendix G, Appraisal Guidelines is replaced with the Nursing Facilities Reimbursement Appendix – Appraisal Guidelines (Attachment A).
- Appendix H, Account Descriptions for Cost Reporting was revised. Some contents were incorporated into the text of the chapter. The listing of Cost Reporting and Reimbursement Descriptions and Classifications is now the Nursing Facilities Reimbursement Appendix – Cost Reporting and Reimbursement Descriptions and Classifications (Attachment B).
- Appendix M, Fixed Asset Value Listing has been incorporated into the chapter text. Classification of assets is covered with reference to the AHA Health Data & Coding Standards Group Estimated Lives of Depreciable Assets.

New Forms

- The Nurse Aide Training and Competency Evaluation Program CNA Reimbursement Form. This form is intended to be used by Certified Nurse Aides to request reimbursement from their nursing facility employer for training and testing costs.

Manual Maintenance

When this policy is finalized, perform the following manual maintenance:

- replace Long Term Care Manual - Chapter VII with the attached chapter.
- discard the following chapters, appendices, and bulletins:
  - Long Term Care Manual - Chapter VIIA
  - Appendix G, Appraisal Guidelines
  - Appendix H, Account Descriptions for Cost Reporting
  - Appendix M, Fixed Asset Value Listing
  - Bulletin Nursing Facilities 04-01, Revision to Nursing Facilities Bulletin 03-08, Section 2
  - Bulletin Nursing Facilities 03-08, Nursing Facility Per Diem Rate Determination, Quality Programs for FY 2003-2004, Class I Rate Relief
  - Bulletin Nursing Facilities 02-03, Quality Assurance Adjustment

- Bulletin LTC 00-04, Nursing Home Quality Incentive Program
- Bulletin LTC 00-03, Special Rate Relief
- Bulletin LTC 00-02, Nursing Home Quality Incentive Program
- Bulletin #5370-90-05, Reimbursement for Newly Certified Hospital LTC Units
- Bulletin #5370-90-03, Nurse Aide Training Refunds
- Bulletin #5370-81-05, New Medicaid Interim Payment (MIP) Program
- Provider Identification Numbers (MIP and Non-MIP Facilities)

- maintain the following bulletins until the audit covering the relevant cost reporting period is done:
  - Bulletin Nursing Facilities 03-05, Quality Assurance Adjustment for Publicly-Owned Class III Nursing Facilities (Retain until your cost settlement is completed for relevant years.)
  - Bulletin Nursing Facilities 02-05, Quality Assurance Adjustment (Retain until your cost settlement is completed for relevant years.)
  - Bulletin LTC 01-08, Implementation of FY 2002 Rates for Class I and Class III Providers, Executive Order 2001-9
  - Bulletin LTC 01-02, Implementation of FY 2001 Rate Increase and Continuation of Wage Pass-Through Program for Class I and Class III Providers
  - Bulletin LTC 99-02, Proportionate Share Pool
  - Bulletin LTC 96-07, Wage Pass Through (These records should be retained for audit purposes.)
  - Bulletin LTC 95-05, Wage Pass Through (These records should be retained for audit purposes.)
  - Bulletin LTC 94-09, Wage Pass Through (These records should be retained for audit purposes.)
  - Bulletin LTC 94-01, Wage Pass Through (These records should be retained for audit purposes.)
  - Bulletin LTC 93-05, Nurse Aide Training

- The following bulletin remains in effect:
  - Bulletin Nursing Facilities 03-01, Implementation of Executive Order 2002-22; Rate Reduction

Medicaid Provider Manual

LONG TERM CARE COST REPORTING AND REIMBURSEMENT

TABLE OF CONTENTS

Medicaid Provider Manual

SECTION 1 - INTRODUCTION

This chapter outlines Medicaid policy pertaining to nursing facility ownership, nursing facility reimbursement, nursing facility costs, and nursing facility financial reporting. Cost reporting, rate determination, financial settlement, audit, and appeal processes are addressed in this chapter. Costs classifications, such as plant, variable, allowable and non-allowable add-ons, used to determine nursing facility reimbursement are defined.

Throughout the chapter references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Community Health (MDCH), Medical Services Administration, is the designated SMA, and is responsible for administration of the Medicaid program. The MDCH Bureau of Health Systems is the designated SSA.

1.1 REIMBURSEMENT RATE METHODOLOGY - GENERAL

The Medicaid nursing facility reimbursement rate is prospectively determined based on the nursing facility's historical costs, which are subject to limitations put forth in policy. Participating Medicaid providers' nursing facility resident days and cost information are reported to the SMA on an annual cost report submitted by the nursing facility. The nursing facility industry aggregate cost data is used to analyze and determine facility class reimbursement limits and related cost levels necessary for calculating nursing facility per diem rates and other analysis. The facility's routine nursing care per diem rate includes plant and variable cost based on the facility's audit allowable costs, measured against classwide rate limitations. Additional reimbursement for specific services outside of the routine nursing care per diem rate are also analyzed and determined from the facility's annual cost report and included in the Medicaid annual reimbursement settlement.

The intent of the Medicaid nursing facility reimbursement system is to:

- Assure high quality services at reasonable costs.
- Encourage the efficient use of nursing care resources.
- Provide reimbursement for allowable costs incurred by prudent, cost-conscious facility managers.
- Provide a review and appeal mechanism to assure that nursing facility providers receive fair and equitable treatment.

1.2 MEDICARE PRINCIPLES OF REIMBURSEMENT

Unless stated otherwise in this chapter, Medicaid reimbursement rates are determined for nursing facilities in accordance with the federal Principles of Reimbursement established for the Medicare Program. Nursing facility providers are expected to comply with applicable provisions in these Principles, with policies published by the SMA, and with all relevant federal and state statutes, rules and regulations. When reviewing the Principles of Reimbursement, any references to "intermediary" should be interpreted as referring to the SMA.

Medicare Principles of Reimbursement appear in the Code of Federal Regulations (CFR), at Title 42, Part 413, and in manuals published by the federal Centers for Medicare and Medicaid Services (CMS). The Provider Reimbursement Manual, also referred to as PRM-15 and Pub. 15, may be obtained from CMS electronically or by contacting CMS as indicated below:

- Download a copy from the CMS web site at http://cms.hhs.gov/manuals/cmstoc.asp; or
- Order a paper copy by contacting the Centers for Medicare and Medicaid Services at:
  - 7500 Security Boulevard, Baltimore, Maryland 21244; or
  - 1-800-MEDICARE (1-800-633-4227).

SECTION 2 - OWNERSHIP CHANGES AND MEDICAID TERMINATION

2.1 PREREQUISITE

When an ownership change is anticipated the Certificate of Need (CON) requirement must be satisfied before Medicaid certification can occur. The Department of Community Health, Bureau of Health Systems office, administers the CON Program. Contact information and subject matters pertaining to the CON may be found on-line at www.michigan.gov/mdch, click on Health Systems & Licensing, Bureau of Health Systems, Certificate of Need.

2.2 OWNERSHIP CHANGES

When an ownership change is anticipated, the proposed Seller(s) and the proposed Purchaser(s) must provide written notice to both the State Medicaid Agency (SMA) and the State Survey Agency (SSA) at least 90 days prior to the anticipated ownership change. The written notice to the SMA must be sent to the MDCH LTC Reimbursement and Rate Setting Section (RARSS) and to the Provider Enrollment Unit. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The written notice to the SSA must be sent to the nursing facility's licensing officer. Failure to provide written notice to either agency could result in payment and settlement delays.

Prior to the ownership change date, the new ownership must complete a New Provider Information Packet to provide RARSS with the necessary information for the rate setting and reimbursement process. Failure to provide this information prior to or immediately upon completion of the purchase will delay the rate setting and reimbursement processing for the new ownership. For New Facility/Owner Requirements, refer to the Cost Reporting Section of this chapter.

Depending on the circumstances of the change in ownership, the new owner may be required to complete a new Medical Assistance Provider Enrollment and Trading Partner Agreement, and obtain a new provider number. If a new provider number is required, the new owner must not use the prior owner's Medicaid provider number for reporting and billing Medicaid services. Failure of the new ownership to secure a new provider number for billing subjects the new owner to financial responsibility for the prior owner's claim liability. Refer to the Provider Enrollment Section, General Information for Providers Chapter of the Medicaid Provider Manual for provider agreement requirements.

The Seller(s) and the Purchaser(s) will be notified by RARSS and advised of any requirements related to cost reporting and rate setting, including final settlement for the former owner. For information regarding reimbursement settlement, refer to the Cost Report Reimbursement Settlement Section of this chapter.

2.3 NURSING FACILITY SALE BETWEEN FAMILY MEMBERS

The sale of a family owned nursing facility between family members is allowable and recognized as a transfer of ownership and an acceptable sale transaction for Medicaid reimbursement within allowable cost and reimbursement limits if **all** of the following requirements are met:

- A purchase contract or agreement must be present. The transaction must terminate the seller's interest in the business. The seller must not have any recourse or ownership protection to retain or have a security interest in obtaining future ownership of that nursing facility in the event of the termination of the new ownership (purchaser) at a later date.
- Borrowing or financing for the sale transaction must be between the purchaser and a non–related third party (i.e., a financial institution). Financial loans from the family-related seller individual or entity to the family-related purchaser are not allowable for reimbursement. The finance instrument must not be a land contract from the seller.
- Total dollar amount of allowable borrowings cannot exceed the purchase price (allowable asset value). The Capital Asset Value (CAV) limit applicable to the nursing facility immediately prior to the sale, appropriately adjusted for nursing facility asset items that are excluded from the sale transaction, is the maximum reimbursable borrowing balance applicable to the asset transaction.
- The nursing facility property appraisal must be obtained. The facility appraisal value must support the purchase price negotiated between the sales parties. Refer to the appraisal guidelines in the Nursing Facilities Reimbursement Appendix of this chapter.
- The new ownership operation must be a different legal entity, in which the family-related seller is not an officer or board member exercising control over the new operation. The nursing facility entity may remain as an ongoing business entity in a situation where the real estate sale does not involve the licensed nursing facility operator. This occurs where a related party lease exists between the nursing facility entity prior to the real estate transaction, and the real estate transaction of the leased nursing facility is between the family-related parties. The requirement that the family-related lessor/seller cannot exercise active interest or control in the management of the nursing facility after the sale must be met.

The following will be applied to a change in ownership as a result of a sale between family members:

- The allowable asset value to the purchaser is limited to the allowable historical capital asset cost of the seller party (or nursing facility entity owned by the related party) minus the dollar amount of depreciation expense allowed and reimbursed under the Medicaid Program. There is no increase in nursing facility asset values. MDCH considers Medicaid reimbursement to the nursing facility for depreciation expense was zero dollars during the time period that the seller provider was reimbursed by Medicaid for plant cost based upon capital asset value tenure reimbursement rate.
- The tenure factor for the nursing facility following the sale will revert to zero due to the capital asset transaction affecting a plant cost increase.
- The Medicaid program plant cost reimbursement limitations of the Deficit Reduction Act (DEFRA) of 1984 will not apply to the transaction as a result of the purchase limitation to the historical asset cost base of the seller.
- The seller may be subject to depreciation recapture dependent on the sale price of the assets and the depreciation reimbursement made to the seller during the time period in which the seller was reimbursed a plant cost component under the depreciation cost method. The reimbursement period of depreciation recapture is limited to Medicaid services reimbursed during the time period from October 1, 1984 through the date in which the nursing facility transferred to the tenure plant cost component reimbursement. The dollar amount of depreciation recapture may impact the asset acquisition allowable dollar amount for the purchaser.

2.4 Facility Asset Change of Ownership

In the event of a binding agreement and/or sale occurring on or after July 18, 1984, the Plant Cost Component for the nursing facility, attributable to the agreement and/or sale, is limited to the Medicaid Program policy provisions applying federal reimbursement limits of the DEFRA. Refer to the plant cost component rate determination provisions in the Rate Determination Section of this chapter for additional information.

At the time of the facility asset ownership change, the Provider must complete a Plant Cost Certification and submit a copy of the purchase and/or lease agreement, along with plant cost information, to the LTC Reimbursement and Rate Setting Section. The information is necessary to establish the reimbursement rate Plant Cost Component due to the asset ownership change. For Plant Cost Certification requirements and timeframes for filing the data, refer to the Plant Cost Certification Section of this chapter.

For an explanation of the effect of the sale of assets on the Tenure Factor, refer to the Rate Determination Section of this chapter.

In the event of a sale after March 31, 1985, Medicaid will recapture from the selling provider any reimbursement received in the form of depreciation expense, through the date of either the sale and transfer of assets or, for a Class I facility, that provider's conversion to a "Return on Current Asset Value Component" reimbursement, whichever is earlier. This reimbursement provision does not apply to Class I nursing facility providers whose ownership began after March 31, 1985. For information regarding depreciation reimbursement adjustment, refer to the Cost Report Reimbursement Settlements Section of this chapter.

2.5 Termination of Medicaid Participation

A nursing facility that loses its Medicaid certification as a result of regulatory action, irrespective of whether that action requires facility closure, or a nursing facility that chooses to terminate its participation in the Medicaid program without closing must comply with notice and cost reporting requirements. Refer to the Cost Reporting Section in this chapter and to the Nursing Facility Closure Section in the Survey, Certification and Enforcement Chapter for relevant information.

SECTION 3 - DEFINITIONS

General definitions are provided in this section. More detailed explanations are provided in relevant sections related to cost, audit or rate setting.

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Acceptable Cost Report	A complete and accurate accounting of the financial and statistical activities of a nursing facility provider prepared in accordance with Medicaid policy and cost reporting instructions on the electronic format required by the State Medicaid Agency. The cost report must include the certification statement signed by an authorized representative of the nursing facility certifying the cost report as a true, correct and complete statement of facility financial and statistical activities prepared from the nursing facility provider's books and records.
Administrator	A nursing facility administrator is a person(s) who is on site and responsible for the professional administration, supervision and management of the nursing facility and operations as they relate to resident care. The nursing facility administrator must be licensed in accordance with the law in Michigan.
Allowable Costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in Medicare Principles of Reimbursement, as they appear in federal regulations and in manuals published by the federal Centers for Medicare and Medicaid Services, unless stated to the contrary in policies and procedures issued by the State Medicaid Agency.
Ancillary Services	Services for which charges are customarily made in addition to routine services charges. Services defined as ancillary in Medicare Principles of Reimbursement are not treated as routine allowable costs under Medicaid.
Asset Acquisition Cost	The cost or value for a nursing facility asset determined in accordance with Medicare Principles of Reimbursement. Medicaid further defines historical cost as the cost incurred by the present owner in acquiring the asset. ▪ For depreciable assets acquired after July 31, 1970, and before December 1, 1997, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or the fair market value of the asset at the time of its purchase. ▪ For depreciable assets acquired on or after December 1, 1997, the allowable historical cost of the asset may not exceed the historical cost less depreciation allowed to the owner of record as of August 5, 1997 or, if the asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997.

Authorized Representative	An individual who has legal authority to obligate the nursing facility entity. The individual may be an officer, senior or majority partner, possess controlling ownership interest or an appropriate management employee of the nursing home license business entity. For purpose of signatures required for cost reporting and reimbursement request actions, individuals not included in these positions must have designated legal right to act in behalf of the subject business entity.
Available Bed	A bed considered available for occupancy. Beds are considered available except in the following situations: ▪ Unoccupied beds when the facility is under a regulatory Ban on Admissions (does not include beds unoccupied when the facility is under a Denial of Payment for New Admissions action. ▪ Beds covered under a State Medicaid Agency-approved Non-Available Bed Plan; ▪ Beds temporarily unoccupied due to renovation or construction where the State Survey Agency has deemed the beds unacceptable for occupancy.
Available Bed Days	The number of available bed days for a facility is the number of available beds in the facility multiplied by the number of days in the cost reporting period that they are available.
Average of Variable Costs	See Class Average of Variable Costs.
Ban on Admissions	A regulatory/enforcement sanction, imposed by the State Survey Agency (SSA), prohibiting the admission of any new resident(s) into the nursing facility, regardless of payment type, while the prohibition is in effect. Readmissions are allowed during this period on an individual case basis at the discretion of the Agency. A modified ban on admissions is a regulatory/enforcement sanction, imposed by the State Survey Agency, which may be imposed for a period of time after a ban on admissions has ended. The length of the modified ban on admissions is at the discretion of the SSA and may limit the number of new admissions for a designated period of time. **Note:** A Ban on Admissions is different from a Denial of Payment for New Admissions.
Base Costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs (salaries, wages, related payroll taxes, fringe benefits) for departments of nursing, nursing administration, dietary, laundry, divers ional therapy, and social services; food; linen (does not include mattress and mattress support unit); workers compensation; utility costs; consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments. With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as previously defined, are separated into base and support costs using the industry-wide average base-to-variable cost ratio.

Base Costs Per Day	Facility base costs divided by the total number of resident days for the same period.
Base Cost Component, Indexed	See Indexed Base Cost Component.
Base Period	An interval of time from which information is obtained for use in calculation of a prospective reimbursement rate.
Capital Expenditure	Expenditure not limited to cost of construction, engineering, and equipment, which, under Generally Accepted Accounting Principles, is not properly chargeable as an expense of operation.
Census	See Resident Days/Occupancy.
Census Day	A census day is counted when a resident is occupying a nursing facility bed at midnight. A census day is counted if the resident is away from the facility for therapeutic leave and the facility is at 98 percent occupancy and the facility is paid to hold the bed (therapeutic leave days paid by the resident or Medicaid); the resident is on a one-day stay and the nursing facility is paid for the day; the resident is discharged due to death and the nursing facility is paid for the day. A resident is not counted for census purposes if the resident is admitted to the hospital, even if the facility is being reimbursed by any payer source to hold the bed. A resident is counted for census purposes on the day of admission, but not on the day of discharge except as noted above.
Chain Organization	A group of two or more nursing care facilities, or at least one nursing care facility and another business or entity, that is owned, leased, or through any other device controlled or operated by one organization. Chain nursing facility organizations include, but are not limited to proprietary organizations and various religious, charitable, and governmental organizations, any of which may be engaged in other activities not directly related to health care.
Change of Ownership	The exchange of real property, e.g., a sale of stock or real estate, including a sale of a building housing a nursing facility provider as a lessee; a change in corporate structure for a nursing facility, e.g., a change from a sole proprietorship to a corporation; or any other ownership change that affects the provider/licensed operator of a nursing facility.
Class I Facilities	Proprietary and nonprofit nursing facilities that do not fall under the Class II, Class III, Class IV or Class V definitions. The provider type assigned to this Class is 60.
Class II Facilities	Proprietary nursing facilities for the mentally ill or developmentally disabled (mentally retarded), with a different variable cost limit than Class I facilities. The provider type assigned to this Class is 72.

Class III Facilities	Nonprofit nursing facilities that are county-operated medical care facilities or hospital long term care units. The provider types assigned to this Class are 61 or 62, for the respective facility types.
Class IV Facilities	State-owned and operated institutions for the mentally retarded (developmentally disabled), Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and nonprofit nursing facilities for the mentally retarded. The provider type assigned to this Class is 65.
Class V Facilities	A distinct part of a special nursing facility for the care of ventilator-dependent residents. The provider type assigned to this Class is 63.
Class VI Facilities	Hospitals that provide a program of short-term nursing care (Swing Beds) not exceeding 100 days per stay. The provider type assigned to this Class is 63.
Class Average of Variable Costs (AVC)	The total *indexed* variable costs for all facilities in a class divided by the total resident days for all facilities in the class. An AVC is calculated for each nursing facility class. For example, the AVC for October 1, 2003, which is used for rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports for facility fiscal years ending in 2002, indexed to October 1, 2002.
Class Variable Cost Limit (VCL)	A limit set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in a particular class during the current calendar year. The 80th percentile is determined by rank ordering facilities from the lowest to the highest IVC, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the class are reached. The Variable Cost Limit for the class of facilities equals the IVC of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities. For example, the VCL for October 1, 2003, which is used for rate year October 1, 2003 through September 30, 2004, is based on variable costs reported in cost reports for facility fiscal years ending in 2002, indexed to October 1, 2002.
Common Ownership	A situation in which more than one individual possesses significant (5% or greater) ownership or equity in a nursing facility or an organization serving the nursing facility provider.
Compensation	The total monetary, fringe, and/or benefits received by an employee or owner for services rendered to the nursing facility.
Control	A situation where an individual or organization has the power, directly or indirectly, to significantly influence and/or direct the actions or policies of a nursing facility or an organization serving the nursing facility provider.
Corporate Official or Employee	An individual representing an organization with the authority to exercise control over a nursing facility.

Cost Center	A division, department, or subdivision thereof; a group of services; or any other unit or type of activity into which functions of an organization or nursing facility are divided for purposes of cost assignment and allocation.
Cost Index	An indicator used to adjust nursing facility cost levels. The cost index used by Medicaid is Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index is used to adjust reported costs from the facility's cost report period end date to October 1 of the year that is one year prior to the rate year being calculated. For example, cost report data used to set rates for the October 1, 2003 to September 30, 2004 nursing facility rate year are indexed to October 1, 2002.
Cost Report	A formal compilation of the nursing facility ownership, financial and statistical data in MDCH prescribed format, and required on an annual basis for the reporting period generally extending over a 12-month period based on the nursing facility's fiscal year. Each nursing facility provider's cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility.
Current Provider	The provider that operated the nursing facility during the time period of the last cost report on which normal rate setting would occur. Also see Provider.
DEFRA	Deficit Reduction Act of 1984
Denial of Payment for New Admissions (DPNA)	A regulatory/enforcement action, imposed by the State Survey Agency or the State Medicaid Agency, prohibiting payment for new Medicare and/or Medicaid admissions. Medicaid will not pay for services provided to a resident admitted after the effective date of the action. **Note:** A Denial of Payment for New Admissions is different from a Ban on Admissions.
Economic Inflation Rate	The annual economic inflation percentage for Class I and Class III nursing facilities established by the state legislature through the appropriations process.
Economic Inflation Update	The Economic Inflation Rate (EIR) for the facility class applied to the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Facility	An entire nursing facility or a distinct part thereof being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes if the identified facility space area meets required certification requirements.
Fair Market Value	The price that an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition, generally comparable to the price at which other sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.

Fiscal Year - Facility	For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for exception due to change in provider ownership or fiscal period end date change.
Fiscal Year – State	October 1 through September 30.
Fixed Equipment (Major)	Equipment that is affixed to or constitutes a structural component of the nursing facility as defined by the current version of the American Hospital Association Chart of Accounts.
Hold A Bed Day	See Leave Day.
Home Office	The central office of a chain organization (See Chain Organization.)
Hospital-Attached Long Term Care Unit (HLTCU)	A distinct part of a general hospital licensed as a nursing facility.
Hospital Leave Day	See Leave Day - Hospital.
Indexed Base Cost Component	A facility's total per resident day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.
Indexed Support Cost Component	A facility's indexed base cost component multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that facility's bed-size group.
Indexed Variable Costs	The sum of a facility's allowable base and support costs per resident day indexed to October 1 of the year that is one year prior to the rate year being calculated.
Leave Day – Hospital	A Medicaid-reimbursable day (up to 10 inpatient days per hospital stay), for a resident who has been admitted to a hospital for emergency treatment, but only if the resident is expected to return to the nursing facility within 10 days and only for those days where the facility's occupancy rate is at least 98 percent. The resident's bed is held for his/her return. The day is not counted as a census day of care for resident occupancy on the nursing facility's cost report.
Leave Day – Therapeutic	A Medicaid-reimbursable day (up to 18 days are allowed during a 365-day period), for a resident who has a temporary absence from the nursing facility for therapeutic reasons as approved by a physician, e.g., to spend time with the family and only for those days where the facility's occupancy rate is at least 98 percent. The resident's bed is held for his/her return. The day is counted as a census day of care for resident occupancy on the nursing facility's cost report.
Management Company	An entity contracted by a licensed and Medicaid-enrolled nursing facility provider to manage one or more of the daily operations of the facility.

Medical Care Facility (MCF)	A county-operated nursing facility.
Net Quality Assurance Supplement (Net QAS)	The Quality Assurance Supplement minus the bed fee assessment (fee per licensed bed per day.
New Facility (for rate-setting purposes)	A nursing facility provider that does not have a current Medicaid historical cost, including a newly constructed facility or an existing facility that has never before participated in the Medicaid program, or a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. A nursing facility that has made physical plant additions and/or renovations, including a total replacement or a facility that has been sold or resold is not considered a new facility.
New Provider in a Medicaid-Enrolled Facility	A person or business entity that has purchased or is purchasing a nursing facility that previously had Medicaid participation and whose new ownership individual(s) or business entity are not related through family or business ties to the owner's business entity of the previous owner. Under certain circumstances, a sale between family members may be approved by the State Medicaid Agency and the new owner may be considered a new provider.
Nursing Facility or Nursing Home	A facility (or distinct part of a facility) that is licensed by the State of Michigan to provide nursing care and related medical services for residents who require such care above the level of room and board.
OBRA	The federal Omnibus Budget Reconciliation Act, initially passed in 1987 as Public Law 100-203, with amendments in 1988, 1989, 1990 and 1994. This law incorporated specific provisions for nursing facility reform, including revised requirements for the survey and certification process and for the enforcement process.
Occupancy	See Resident Days/Occupancy.
Occupancy Rate	The total number of resident days in a given time period divided by the number of available bed days in the facility for the same time period.
Owner/Administrator	A person who is the administrator, assistant administrator, business manager, or other administrative employee of a nursing facility, and who is also part or full owner of the nursing facility operating entity, i.e., the provider and/or the nursing facility real property.

Ownership/Corporate Interest	A person, partnership, or corporation that: ▪ Has ownership interest totaling 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has an indirect ownership interest equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has a combination of direct and indirect ownership interests equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility, if that interest equals at least 5% of the value of the property or assets of the facility/disclosing entity; or ▪ Is an officer or director of a nursing facility, i.e., in the disclosing entity, that is organized as a corporation; or Is a partner in a nursing facility, i.e., in the disclosing entity, which is organized as a partnership. **Examples:** ▪ If Ms. C owns 10% of a note secured by 60% of the nursing facility provider's assets, Ms. C's interest in the provider's assets equates to 6% and must be reported. Conversely, if Mr. S owns 40% of a note secured by 10% of the provider's assets, Mr. S's interest in the provider's assets equates to 4% and need not be reported. ▪ If Mr. F owns 10% of the stock in a corporation that owns 80% of the nursing facility, Mr. F's interest equates to an 8% indirect ownership interest and must be reported. Conversely, if Ms. N owns 80% of the stock of a corporation that owns 5% of the stock of the nursing facility, Ms. N's interest equates to 4% indirect ownership interest and need not be reported.
Patient	See Resident.
Per Resident Day Cost	The total cost for a cost component divided by the total number of resident days. The number of resident days used is the greater of the number of resident days listed in the facility's cost report or 85% of the total number of available bed days for the cost reporting period.
Plant Costs	Plant costs include depreciation, interest expense (either working capital or capital indebtedness), property taxes, amortization costs associated with loan financing costs (e.g., discount points, letters of credit), and specific lease expenses.
Property Owner	A person, partnership, corporation, organization, or entity, other than the nursing facility provider, having the property rights to the building in which a nursing facility operates or to the land on which a nursing facility sits.

Proprietary Provider	A provider or organization that is organized and operated with the expectation of earning profit for its owner[s], as distinguished from providers organized and operated on a nonprofit basis. Proprietary providers may be sole proprietorships, partnerships, or corporations.
Provider	A legal entity (person, partnership, corporation, or organization) that has been approved to participate in the Michigan Medicaid Program and has signed a Medical Assistance Provider Enrollment and Trading Partner Agreement. Some conditions of provider participation continue after enrollment in Medicaid has ended, e.g., record retention.
Purchase Allowance	A deduction granted for damage, delay, shortage, imperfection, or other causes, excluding discount and return.
Purchase Discount	A reduction (off the original price for property, goods or services) granted for the settlement of debts (e.g., 5/10 days which means a 5% discount if paid within 10 days).
Purchase Price	The total price agreed upon between a buyer and a seller for property, goods or services.
Quality Assurance Assessment Factor (QAAF)	The percentage increase determined and implemented by Medicaid for a class of nursing facilities.
Quality Assurance Supplement (QAS)	The product of the QAAF for the class times the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Related Entity or Organization	An entity having a business relationship with a nursing facility provider that has 5% or greater beneficial interest or common ownership in or has control of the facility or the facility owner, whether such control has legal standing or is utilized. Also see Chain Organization and Ownership/Corporate Interest.
Related Party	An individual, group of individuals, or business entity that meets criteria similar to that defining a related entity or organization.
Resident Days/Occupancy	Resident days or occupancy for a nursing facility is the sum of the census days in a specified period of time. To calculate the resident days for a particular day, total the census days for that day. (Residents who are hospitalized are not counted in the census). **Example:** Residents occupying beds in facility = 100 Residents on therapeutic leave = 5 Residents hospitalized = 3 Total resident days = 105

Routine Nursing Services	Organized nursing care and activities for the resident, under the observation and assessment of licensed nurses, that enable the resident to attain or to maintain the highest practicable physical, mental, and psychosocial well being in accordance with a written plan of care.
Routine Nursing Costs	Costs including, but not limited to, necessary medical, nursing, and mental health services, and all items of expense that nursing facility providers incur in the provision of routine nursing services. Costs must be included in the nursing facility provider's Medicaid cost reporting in accordance with established cost classifications.
State Medicaid Agency	The Michigan Department of Community Health. The work unit within the department with administrative responsibility for the Medical Assistance (Medicaid) Program is the Medical Services Administration.
State Survey Agency	The Michigan Department of Community Health. The work unit within the department with administrative responsibility for nursing facility survey and certification is the Bureau of Health Systems.
Support Costs	Costs that are payroll and benefit-related (salaries, wages, related payroll taxes, fringe benefits) for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration; administrative costs; all consultant costs not specifically identified as base; all equipment maintenance and repair costs; purchased services; and contract labor not specified as base costs.
Support Costs Per Day	A facility's support costs divided by the total number of resident days for the same period.
Support Cost Component, Indexed	See Indexed Support Cost Component.
Support-to-Base Ratio	A facility's allowable support costs divided by allowable base costs. A facility's support-to-base ratio is limited to the 80th percentile support-to-base ratio for the facility's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of bed type or whether the bed is available. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed bed where nursing care is provided. A facility's support-to-base ratio is rebased annually from the most recent audited base period, regardless of ownership.
Support-to-Base Ratio Limit for Bed Size Group	The support-to-base ratio limit for a bed-size group is set at the 80th percentile of the support-to-base ratios for facilities in the same bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. The 80th percentile is determined by rank-ordering facilities within the same bed-size group from the lowest to the highest support-to-base ratio, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the group are reached. The support-to-base ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs.

Swing Beds	A program of short-term nursing care not exceeding 100 days, provided to patients in a hospital as defined in federal law and Michigan statute.
Therapeutic Leave Day	See Leave Day – Therapeutic.
Variable Costs	A facility's total allowable base and support costs for providing routine nursing services to residents, as determined in the Allowable Costs Section of this Chapter. Also see definitions for Base Costs and Support Costs.
Variable Cost Component	The lesser of a facility's Variable Rate Base or the Class Variable Cost Limit, plus the Economic Inflation Update.
Variable Cost Limit	See Class Variable Cost Limit.
Variable Costs Per Day	A facility's variable costs (total base and support costs) divided by the total number of resident days for the same period.
Variable Costs, Indexed	See Indexed Variable Costs.
Variable Rate Base	The sum of a facility's indexed base cost component and indexed support cost component. For rate setting purposes, the figure used as the facility's Variable Rate Base is the lesser of the facility's calculated Variable Rate Base or the Class Variable Cost Limit.

SECTION 4 - COST REPORTING

A nursing facility participating in the Medicaid program, must submit a Medicaid cost report to the MDCH annually as a condition of participation. An electronic copy of the cost report, the cost report completion instructions, completion and submission checklists, and related information are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

4.1 EXCEPTIONS

4.1.A. EXCEPTION FOR HOSPICE PROVIDER OWNED NURSING FACILITY

A hospice provider that owns and operates a nursing facility is not required to file an annual cost report to Medicaid. The nursing facility industry aggregate cost data is used in place of individual facility cost data to establish a Medicaid reimbursement rate for this type of nursing facility. Rate determination procedures are addressed in the Rate Determination Section of this chapter.

4.1.B. EXCEPTION FOR SWING BEDS

Hospitals providing short term nursing services (swing beds) are not required to submit a Medicaid nursing facility cost report to the Agency. Costs associated with swing beds are combined with those of the hospital and submitted on the hospital cost report. Refer to the Hospital Chapter of the Medicaid Provider Manual for information regarding cost reporting requirements related to swing beds.

4.2 NURSING FACILITY COST REPORT

An annual cost report is required for the cost reporting period which is based on the nursing facility's fiscal reporting year. Each cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility. These records must be maintained in a manner consistent with cost finding regulations in the Medicare Principles of Reimbursement except where modified by Medicaid reimbursement and cost reporting policy. Records must also be kept in a manner consistent with previous cost reporting periods. The accrual method of accounting is mandated for non-governmental providers. Where governmental institutions operate on a cash basis of accounting, cost data reported on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures as discussed in the Cost Classification and Cost Finding Section of this chapter.

Related organizations and costs to related organizations, as defined in federal regulations, must be disclosed on the nursing facility cost report. Related organization costs claimed for Medicaid reimbursement through the nursing facility's rate determination process must be documented to RARSS on a completed home office cost report or an alternative cost reporting schedules as defined in the Home Office Cost Report subsection of this chapter.

For any cost situation that is not covered by the Medicare Principles of Reimbursement guidelines or Medicaid policy, Generally Accepted Accounting Principles (GAAP) should be applied.

RARSS retains the filed nursing facility cost reports for a minimum of 3 years from the date of receipt. Nursing facilities are required to retain documentation supporting filed cost reports for a minimum of 7 years from the end of the applicable cost reporting period, or beyond the 7 year period if audit determinations have not been resolved.

4.3 Cost Report Requirements

The RARSS will mail a notice to the facility or business office as designated by the provider soon after the end date of the nursing facility's cost reporting period on record. The notice specifies the nursing facility's county and license number coding, fiscal reporting period end date, cost report due date, and other pertinent data necessary for the completion of the cost report. This notice is mailed to the nursing facility or business office address as designated by the provider on file with RARSS. The provider will also receive a compact disk (CD) with the specific information required to file an acceptable Medicaid Cost Report package in an electronic format. The CD has the applicable electronic cost report template, completion instructions, Marshall Valuation Services Cost Multiplier index for asset acquisitions, and other pertinent information.

The completed cost report package submitted to RARSS must include:

- The standardized electronic cost report (ECR) data in accordance with specified formatting and software.
- A paper copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report.
- A copy of the nursing facility's trial balance of revenues and expenses.
- A completed cost report submission checklist.

The completed cost report package must either be mailed or delivered to RARSS as indicated in the notice.

4.4 Cost Report Acceptance

Each cost report submitted to RARSS is verified prior to its acceptance. The cost report package will only be accepted if all the following conditions are met:

- The package is complete.
- The cost report calculations are mathematically accurate, reasonable and consistent.
- The completed electronic cost report (ECR) data uses the required software and specified format.
- MDCH audit staff can generate a full cost report applicable to the cost year from the ECR file.
- The paper copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file.
- The data meets a set of validation checks contained within the ECR plus the appropriate bed size and certification reporting requirements.
- The cost report preparation complies with Medicaid policy and cost reporting instructions. The cost report data may be subject to a more detailed review in the cost report audit process.

A cost report is considered not filed until it is accepted by RARSS. If the submitted cost report is determined to be unacceptable, RARSS will return the cost report to the nursing facility for correction and provide notice of the date the corrected cost report is due. The returned cost report will include information that indicates the reason(s) for the unacceptable report.

4.5 Less Than Complete Cost Report

With written approval from the RARSS, a nursing facility may submit a less than complete cost report.

4.5.A. No Medicaid Utilization

A nursing facility that has not furnished any services to Medicaid beneficiaries during the entire cost reporting period does not need to submit a cost report to comply with Medicaid's cost reporting requirements. The nursing facility may replace the cost report with a letter signed by an authorized representative that identifies the cost reporting period to which the statement applies (includes the facility name and Medicaid provider ID number), and states that:

- No covered services were furnished during the reporting period.
- No claims for Medicaid reimbursement will be filed for this reporting period.

The signed statement must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

4.5.B. Low Medicaid Utilization

RARSS may authorize a less than complete cost report for a nursing facility with low utilization of Medicaid services in a reporting period. "Low utilization" is defined as an average of five or fewer Medicaid residents per day in the facility for the cost year, i.e., fewer than 1,825 Medicaid nursing days. The nursing facility must submit a written request to RARSS for approval to file a less than complete cost report for the specific cost reporting period. The request must be signed by an authorized representative of the nursing facility, identify the reporting period the request applies to, include the facility's name and Medicaid provider ID number, and:

- Indicate the reason(s) for the request.
- Indicate Medicaid utilization and the approximate Medicaid dollar amount of payments received for the year.

The written request must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

After RARSS reviews the filed utilization and payment information, RARSS will send a written response to approve or deny the facility's request to submit a less than complete cost report. If approved, the facility will be required to furnish the following information using the required formats (ECR file worksheets):

- Information and Certification page.

- Statistical and Fiscal Data page.
- Ownership Information and Questionnaire.

In addition, the facility must prepare and submit the following information for the cost reporting period:

- Balance Sheet, and
- Prepared Financial Statements.

The nursing facility must submit the data within the same time period required for complete cost reports. Medicaid reserves the right to require the facility to file a complete cost report.

4.6 Cost Report Due Date

The RARSS will notify the nursing facility of the cost report due date by letter mailed to the nursing facility or designated business office. An acceptable cost report must be received by RARSS within five months following the nursing facility's cost reporting period end date. Subsequent notice of the cost report due date is addressed in the Cost Report Delinquency subsection of this chapter.

A cost report is considered filed timely if the acceptable cost report is submitted to the RARSS on or before the last day of the fifth month following the cost report period end date. Late submission of an acceptable cost report may cause a delay in determination of the annual reimbursement rate and notice to the provider. Refer to the Rate Determination subsection of this Chapter for additional information.

4.6.A. Corrected Cost Report Due Date

If the cost report is returned to the provider unaccepted, the provider is given 15 calendar days from the date that RARSS returned the cost report to resubmit a corrected cost report. A written request for an extension may be made to RARSS for additional days (not to exceed 30 calendar days from the return date). The RARSS will notify the provider in writing of the extension decision. If a corrected cost report is not received by the correction due date, the nursing facility is subject to cost report delinquency and payment termination notification. Refer to the Cost Report Delinquency subsection of this chapter for additional information.

4.6.B. Cost Report for Facility Closure or Change of Ownership

A nursing facility that has terminated its Medicaid program participation, either voluntarily or as the result of regulatory action, is required to submit a final cost report within five months following termination date.

The former owner of a nursing facility that has undergone a change of ownership is required to submit a final cost report within five months following the effective date of the ownership change.

4.7 New Facility/Owner Requirements

A new Medicaid provider (either a new owner or a newly Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. In order for RARSS to establish the facility's Medicaid reimbursement rate, this notice must be submitted to MDCH at least 30 calendar days prior to the begin date of Medicaid participation. Untimely submission of the data will result in delaying Medicaid payment to the nursing facility.

The new provider information packet is available by request to the RARSS. An electronic copy of the packet may also be accessed on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact and website information.)

The new provider information data must include the following items:

- Operations begin date.
- Fiscal year reporting period.
- Federal employer identification number.
- Facility business name.
- Corporate name (if different from business name).
- Facility address.
- Business mail address (if different from facility address).
- Affiliation to a home office chain or related nursing facility group, including corporate organization, address, fiscal reporting time period, federal employer identification number and contact person information.
- Nursing facility Medicare Program status.

The new provider information data packet must be signed and submitted by an authorized representative of the nursing facility.

4.8 Changing a Cost Reporting Period

An annual cost report is required for the reporting period based on the nursing facility's fiscal reporting year. A nursing facility provider must file an annual cost report in accordance with the cost reporting period established with RARSS. However, under certain circumstances, RARSS may authorize a change in the nursing facility cost reporting period. The new cost reporting period must concur with the time period of the nursing facility financial reporting year.

4.8.A. New Facility/New Ownership Initial Cost Report

A new Medicaid provider (either a new owner or a newly Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. The initial cost report must cover a period of at least two months but may not exceed 13 months.

4.8.B. Written Request for Cost Reporting Period Change

A nursing facility owner interested in changing a cost reporting period must submit a written request to RARSS. The request for such a change must be filed at least two months prior to the first day of the new fiscal reporting period being requested. The request must include documentation supporting the change, such as a copy of an approval of Medicare Program reporting change or Internal Revenue Service reporting year change notice. If the reporting year change is not yet approved by these agencies, a copy of notice of Internal Revenue Service reporting or application for Medicare Program reporting change may be submitted. The request must also include a copy of the nursing facility director or governing board approval resolution or minutes adopting the fiscal reporting revision.

RARSS will notify the provider in writing of the approval or denial of the request and cost report time period requirements resulting from the request.

4.8.C. Approval for Transition Period Cost Reporting

If the change is approved, the nursing facility will be required to file a cost report for the period between the end date of the original cost reporting period and the beginning date of the new cost reporting period. This cost report must cover a time period not less than two months and not more than 13 months. Cost report periods that cover a period less than 7 months may be used for Medicaid reimbursement for retrospective cost settlement determination for specific cost items, but are not used for prospective rate setting determinations affecting a subsequent rate setting year.

4.8.D. Extended Period Cost Report

A provider may submit a request for a cost report period of more than 13 months if the:

- Provider is in the initial cost reporting period.
- Provider is terminating Medicaid Program participation.
- Facility is closing.

Written request must be made to the RARSS and must outline the exceptional circumstances. The provider will be notified in writing of approval or denial.

The RARSS may approve such requests if the Medicaid program or the nursing facility are not significantly adversely affected. Examples of not adversely affected include where:

- the request is not made for purpose to gain access to higher ceiling rates or economic inflation adjustors;
- the cost report data will have limited use for reimbursement determinations, i.e., not used for annual rate setting;
- the report is not used for subsequent time period rate determination;
- it is used solely for retrospective settlement items.

4.9 Cost Report Delinquency

The nursing facility cost report is considered delinquent if:

- An accepted cost report has not been received by RARSS by the cost report due date and the cost report remains not filed with RARSS.
- A corrected cost report has not been received by RARSS by the cost report due date or correction period due date and the cost report remains not filed with RARSS.
- The nursing facility cost report is delinquent, RARSS will send a delinquency and Medicaid payment termination notice by certified mail to the nursing facility or the provider's designated business office. The notice will indicate the date (not less than ten (10) business days from the notice date), on which Medicaid payment will be terminated unless a cost report is received by the RARSS.

If an acceptable cost report is received after payment termination, payments will be reinstated through the normal pay cycle(s) process.

4.10 Amended/Revised Cost Report

A filed cost report consistent, with federal regulations and Medicaid policy governing its preparation, is intended to be final when settlement has been made or following an audit determined to be necessary by Medicaid. An amended cost report to revise a previously submitted cost report may be permitted by Medicaid or may be required by the Medicare Principles of Reimbursement.

An amended cost report may be accepted by Medicaid to:

- Correct material errors detected subsequent to the filing of the original cost report.
- Comply with health insurance policies or regulations.
- Reflect the settlement of a contested liability.

Before completing and submitting an amended cost report, the nursing facility should contact the RARSS by verbal or written communication to determine the appropriate mode for making the necessary amendment(s). Amended cost report data will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning in the month following the receipt of the provider's notice to RARSS of the need to amend the cost report.

The provider must include a disclosure letter with the amended cost report identifying the reason for the amended report and citing the cost report Worksheet(s) and the data input cell(s) within the Worksheet(s) that have been revised.

The provider cannot amend a filed cost report that has been audited. Amended cost reports will not be accepted by RARSS after the completion of an audit except in cases where the filed and audited cost report continues to be the basis for the nursing facility's current reimbursement rate. An amended cost report must properly reflect any audit adjustments made to the original cost report. Corrected or amended data will be used, as appropriate, to compute future rates but will not be used to retroactively change a previously applied prospective rate. Use of amended cost report data for retroactive application to prior services will only be made in cases related to fraud or failure to disclose required information in

the cost reporting. Situations where retroactive changes are permissible are described in the Cost Report Reimbursement Settlements Section of this chapter.

4.11 Home Office Cost Report

Nursing facilities that have costs applicable to services, facilities, and supplies furnished to the provider by organizations or entities related to the nursing facility by common ownership or control may include the costs in the nursing facility cost report. These costs may arise from arrangements involving a home office of a chain organization or services provided to the nursing facility or purchased by the nursing facility from related party businesses.

For facilities that are operated as part of a chain organization, home office costs claimed on the individual nursing facility's cost report must be reported using the Medicare Home Office Cost Statement, Schedules A through J, of the HCFA 287-92.

For nursing facilities reporting costs of services provided by a related party organization, the Medicare Home Office Cost Statement, Schedules A through J, HCFA 287-92 is the recommended format. Alternative cost reporting worksheets or accounting schedules may be substituted for the Home Office Cost Statement if RARSS agrees that the alternative format provides supporting documentation to adequately identify expenses and the allocation of costs to the nursing facility. RARSS will approve the format as submitted, require additional data or revisions to the reporting format, or disapprove the alternative reporting.

The Provider must submit two (2) copies of the annual Home Office Cost Statement or related party cost report.

When the fiscal year for the home office or related organization coincides with the nursing facility's fiscal year, the due date for a home office or related party cost report must coincide with the nursing facility's annual cost report due date. In cases where the fiscal years do not coincide, the nursing facility must submit the cost report of the home office or related party for the most recently completed fiscal year of that entity. The report may have been submitted to RARSS previously, it must be submitted by the same due date as the nursing facility's cost report. (Refer to the Related or Chain Organization Cost Allocation subsection for additional information.)

If the facility does not provide the above referenced supporting documentation to support home office or related party costs, the facility must remove the costs from the nursing facility's cost report. The nursing facility's cost report will not be accepted if the provider does not remove the unsupported costs.

4.11.A. Home Office Costs - Chain Organization

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization.

For Medicaid policy regarding allowable costs, refer to the Cost Classification and Cost Finding Section of this chapter.

4.11.B. Related Party Business Transactions

The operating costs of a related ownership organization are allocated to the individual nursing facility as a purchased service. This cost must be identified within the appropriate cost center in the Medicaid cost report. Identification of the type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility.

The related party cost reporting is required for the specific related party business entity in the following cases:

- If the dollar amount of routine nursing care costs to the individual nursing facility exceeds $10,000 in aggregate, regardless of the number or type of services provided.
- If the sum total dollar amount of routine nursing care costs to multiple nursing facilities exceeds $50,000 in aggregate, regardless of the number or type of services provided and number of nursing facilities served.

These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services.

Facility lease arrangements between related parties must be separately reported in the cost report as described in the Allowable and Non-Allowable Cost Section of this chapter.

4.12 Cost Report Filed Under Protest

As part of the cost settlement and cost report audit process, a nursing facility provider may dispute a Medicaid regulatory or policy interpretation. (Refer to the Appeal Process Section of this chapter for additional information.) If the provider has a dispute regarding the annual cost report, the nursing facility may submit a separate cost report to establish their reporting of the dispute issue. In order to preserve the nursing facility cost report claim, this separate cost report must be identified as under protest for the disputed issues that remain under appeal or are subject to an appeal. The cost report filing must include an accompanying letter, signed by the nursing facility authorized representative, listing the disputed issue(s) and respective dollar amount(s) for the basis of the protest cost report filing. Protest cost reporting issues will be addressed in the cost report audit process dependent upon resolution of the disputed issues.

Protest cost report filing is not for general disagreement with promulgated Medicaid policy. The RARSS will not accept protest cost reports filings that include items considered as disagreement or dissatisfaction with promulgated policy.

SECTION 5 - PLANT COST CERTIFICATION

Medicaid reimburses nursing facilities for costs associated with capital asset ownership. The costs are referred to as plant costs and are reimbursed as the Plant Cost Component of the per diem reimbursement rate. The Plant Cost Component is based on the cost report data submitted by the nursing facility for the previous calendar year. The Plant Cost Component includes costs associated with capital asset acquisition, depreciation, interest expense (either working capital or capital indebtedness), property taxes, amortization costs associated with loan financing costs (discount points, letters of credit, asset acquisition legal fees) and specific lease expenses. The Plant Cost Component of the reimbursement rate determined for a nursing facility remains consistent throughout the State's fiscal year period (October through September), unless the facility qualifies for an interim reimbursement rate.

Example: Plant cost data from cost report year-end December 31, 2002 is the basis for the Plant Cost Component for the October 2003 through September 2004 rate period. Refer to the Cost Classification and Cost Finding, and the Rate Determination sections of this chapter for additional information.

The process used to determine if a facility qualifies for an interim reimbursement rate is called Plant Cost Certification. Special rate setting provisions qualify facilities to use current year costs associated with capital ownership instead of the prior year's cost report data to determine the Plant Cost Component of the reimbursement rate. Rate setting provisions are available for facilities incurring exceptional changes in the facility's plant costs during the current year. Qualifying situations such as new construction or renovation, new asset acquisition, new ownership, or changes in the nursing facility's bed size or the type of resident services are considered to determine eligibility for Plant Cost Certification.

5.1 PLANT COST CERTIFICATION ELIGIBILITY CRITERIA

A facility may plant cost certify when there is no plant cost data available or when the plant cost data inadequately reflects the current period operational costs. Plant Cost Certification is available in the following situations:

- The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, $1500 per licensed bed in capital expenditures in a single cost reporting period.
- There is an approved CON ownership change for an existing facility, or the nursing facility assets have changed ownership in a manner that requires CON review.
- The State Survey Agency has changed the class level of the facility, change in Medicaid certified beds, or the type of nursing or resident care services provided in the nursing facility.
- The nursing facility has an approved non-available bed plan in the cost report period.
- The nursing facility is in the first full cost report year following the termination of an approved non-available bed plan.

5.2 PLANT COST CERTIFICATION SUBMISSION

The provider must complete the Plant Cost Certification process and qualify in order to receive an interim reimbursement rate. The RARSS must receive a compilation of the nursing facility's expected allowable plant costs and a statement signed by the nursing facility's authorized representative attesting to the data's accuracy and adherence to the Plant Cost Certification policy. The provider must use the MDCH

required format for document preparation. A provider having a nursing facility license and leasing the facility must report facility costs of the lessor in accordance with Medicaid's reimbursement policy. Refer to the Allowable Cost and Non-Allowable Cost, and Cost Classification and Cost Finding sections in this chapter for additional information.

A provider requesting an interim reimbursement rate must complete the Medicaid Long Term Care Plant Cost Certification form and submit copies of supporting documentation. The Plant Cost Certification packet is available by request to RARSS. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) An Electronic copy of the packet can also be accessed on the MDCH website.

Supporting documentation must include the following items:

- For Facility Purchase
  - CON approval
  - Purchase Agreement
  - Mortgage and Loan Agreements
  - Interest Amortization Schedules for Financing
  - Property Tax Statements
  - Capital Asset Cost Appraisal
  - Purchase Closing Statement or Recording
- For Renovation, Addition or New Construction
  - CON approval
  - Licensed Bed Notice issued by the State Survey Agency
  - Notice of Licensed Bed Change, if applicable
  - Mortgage and Loan Agreements
  - Interest Amortization Schedules for Financing
  - Property Tax Statements
  - Construction Contract Statement or Summary

The completed form and support documentation may be mailed or delivered to the RARSS. Inquiries relating to the submission of the data should be directed to the RARSS office. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

If RARSS determines that the plant certification eligibility criteria are met, the submitted cost data will be desk reviewed, adjusted if necessary, and used to calculate the nursing facility's Plant Cost Component. If the fiscal year cost report filing and subsequent cost report audit determine the data used to calculate the reimbursement for the Plant Cost Component resulted in an overpayment or underpayment to the provider, the Medicaid recovery or additional reimbursement due the provider is included in the cost report reimbursement settlement. (Refer to the Cost Report Reimbursement Settlement section of this chapter for additional information.)

5.2.A. Plant Cost Certification Requirement for Reimbursement – Building and Equipment Changes

A new or existing provider or business entity operating a nursing facility that is incurring a change involving the nursing facility's building and equipment must complete a Plant Cost Certification. A provider that obtains ownership of the nursing facility building and equipment or enters a lease agreement for the facility must submit a completed Plant Cost Certification.

The Plant Cost Component of the reimbursement rate will be zero until the Plant Cost Certification is received by the RARSS. In order to be eligible for retroactive reimbursement, the provider must submit a completed Plant Cost Certification on or before the date of the initial filing of cost report for the year in which the ownership change or asset transaction occurred. The effective date of the Plant Cost Certification will be the month that new ownership becomes the licensed entity or the asset transaction. Plant Cost Certification requests received by RARSS subsequent to the cost report filing will not be eligible for retroactive reimbursement, and future plant cost reimbursement rates will be effective as outlined under the effective time period policy.

5.2.B. Plant Cost Certification Submission Waiver

If the provider qualifies for Plant Cost Certification under the approved non-available bed plan or because it is the first cost report year after the non-available bed plan termination, the data submission requirement is waived. The provider has the option to file during the rate year or to defer the plant cost rate revision until the cost report reimbursement settlement. Settlement adjustments for plant costs for the cost report period will automatically apply to non-available bed time periods. If a Plant Cost Certification is not filed, the nursing facility's interim Plant Cost Component will continue to be based on the previous year's cost report, and the cost report reimbursement settlement will be adjusted to the allowable plant cost level for the cost report time period. Refer to the Cost Report Reimbursement Settlement section of this chapter for additional information.

5.3 Plant Cost Certification Effective Time Period

The effective time period of the plant cost certification will be determined by the RARSS. A completed Medicaid Long Term Care Plant Cost Certification form, with documentation, received by the RARSS prior to the 16th of the month is effective and included in the reimbursement rate as of the first day of the following month.

Example: A form that is received between September 16 and October 16 will be reflected for days of care beginning November 1.

The effective date of the plant cost certification cannot be prior to the month in which the facility experienced the change of ownership or the qualifying asset change. The rate is not revised for partial months. For interim rate setting, the revised reimbursement rate due to the Plant Cost Certification will not be applied to prior service dates except in instances where a provider meets certification eligibility under the nursing facility ownership change or lease provisions. If a plant cost certification is filed prior to the provider's cost report year end, an interim reimbursement rate is effective on a prospective basis

for service dates after filing date. Retroactive reimbursement due to the plant cost change for that cost report year services will be addressed in the initial and final settlement determination of the cost report. Refer to the Cost Report Reimbursement Section of this Chapter for additional information.

If a Plant Cost Certification is filed after the provider's cost report year end, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the time period established by the Plant Cost Certification request receipt date.

The Plant Cost Certification interim reimbursement ends when the nursing facility's prospective Plant Cost Component is based on the first complete cost report year that reflects the plant costs which qualified the nursing facility for Plant Cost Certification.

Example: A nursing facility with a cost report period of January 1, 2004 through December 31, 2004 completes an eligible renovation project in June 2004, and submits a Plant Cost Certification before June 16, 2004 to be effective July 1, 2004. (**Note**: Rate Year refers to a time period coinciding with the state fiscal year rate period. The time periods listed below the Rate Year identify the period during which the rate will be paid and the cost report year on which the rate is based.)

The nursing facility initial period interim rates for plant cost reimbursement will be:

- Rate Year October 2003 through September 2004:
  - October 2003 - June 2004 - Plant cost for the cost report year end December 2002
  - July 2004 - September 2004 - Plant cost based upon Plant Cost Certification reflecting expected cost for the cost report year end December 2004

The nursing facility final rates for plant cost reimbursement will be:

- Rate Year October 2003 through September 2004:
  - October 2003 - December 2003 - Plant cost for the cost report year end December 2002
  - January 2004 - September 2004 - Plant cost for the cost report year end December 2004
- Rate Year October 2004 through September 2005:
  - October 2004 - December 2004 - Plant cost for the cost report year end December 2004
  - January 2005 - September 2005 - Plant cost for the cost report year end December 2005
- Rate Year October 2005 through September 2006:
  - October 2005 - December 2005 - Plant cost for the cost report year end December 2005
  - January 2006 - September 2006 - Plant cost for the cost report year end December 2006

- Rate Year October 2006 through September 2007:
  - October 2006 - September 2007 - Plant cost for the cost report year end December 2005

5.4 Plant Cost Certification Updates and Revisions

The nursing facility's initial Plant Cost Certification will continue to be used for the interim Plant Cost Component unless the nursing facility submits a revision to the Plant Cost Certification.

Following the initial submission of the Plant Cost Certification, the nursing facility is responsible to submit an updated or revised Plant Cost Certification to assure the interim Plant Cost Component reimbursement is representative of the current rate period plant costs.

The nursing facility provider may revise its submitted Plant Cost Certification plant cost compilation at the beginning of subsequent fiscal year rate periods or the beginning of a calendar quarter, but not more than two times per year. The effective timeframes for payment based on the updated information are the same as noted above.

The overpayment penalty provisions, if applicable, remain in effect regardless of payment based on initial submission or revised data.

5.5 Plant Cost Certification Overpayment Penalty

At the time of the MDCH audit of the provider's fiscal year cost report, if the interim reimbursement payments resulting from Plant Cost Certification exceed cost report settlement plant cost reimbursement, all excess funds paid as a result of the Plant Cost Certification request will be recovered by Medicaid. The provider will be assessed a penalty for overpayments resulting from Plant Cost Certification. The penalty will be based on 10% of the aggregate dollar amount difference between the interim reimbursement payments resulting from the Plant Cost Certification and the cost report settlement plant cost reimbursement. The penalty will be waived if the aggregate dollar amount difference is equal to or less than 10% of the provider's aggregate Plant Cost Component reimbursement amount for the cost settlement period. Overpayment recovery and penalty determination are included in the Cost Report Reimbursement Settlements (Section 7).

SECTION 6 - AUDIT

The goal of the cost report audit is to provide the MDCH assurances that the cost report information is accurate for the determination of Medicaid reimbursement rates, and includes the following objectives:

- To review, analyze, and test the nursing facility's Statement of Reimbursable Cost and underlying financial records to confirm that only reasonable and allowable costs have been included.
- To confirm that the methods used to calculate the required statistical information are adequate and that the statistical data is recorded accurately.
- To confirm that the cost finding and cost apportionment have been accurately and fairly computed.
- To confirm the accuracy of the costs allocated to Medicaid by independently applying the method approved for the provider's use in computing reimbursable cost.
- To confirm that, in all material aspects, the nursing facility provider is in compliance with the reimbursement regulations.
- To review, analyze and test the nursing facility's revenue and billings to determine the propriety of billing practices and identify potential errors and financial risk to Medicaid.
- To identify the underlying causes of significant errors or problems noted during the audit and to suggest improvements.
- To follow up on significant problem areas identified in previous audits.
- To confirm consistent and uniform application of federal and state laws, rules, and regulations for reimbursable costs.

6.1 AUDIT PROCESS

The annual audit process may include a desk audit/review, a computer check, and/or an onsite audit. This process may be performed by MDCH audit staff or by qualified designee.

Onsite audits will be conducted no less than once every four years. An audit of either limited or full scope will be performed on the records of each participating nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines.

A Preliminary Summary of Audit Adjustments Notice is issued to the facility upon completion of the audit.

6.1.A. Required Information

Each provider must allow access or arrange for access by MDCH staff, or their designees, to required financial records and statistical data including:

- Records required by the Medicare Principles of Reimbursement.
- Complete financial records of related organizations.
- Complete records of lessors necessary to determine underlying costs of leasing facilities and items of equipment.

These records include, but are not limited to, the following:

- Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e., hospital, therapeutic).
- Resident medical records, with details of medical services received by each resident.
- Resident service charge schedules.
- Resident trust fund account records, with evidence of quarterly reporting to each resident.
- Medicaid Cost Report with supporting documentation for cost finding statistics utilized on the report.
- Supporting documentation for Nurse Aide Training and Competency Evaluation Program activity and cost data.
- Documentation to support the cost and activity level for special Medicaid reimbursement provisions beyond the scope of services included in routine nursing care.
- Total and Medicaid ancillary charge summaries and logs.
- Medicare Cost Report, if applicable.
- Medicare and other health insurance billing and payment records for each resident.
- Books of original entry, including standard/special journals, payroll journals, disbursement journals, etc.
- Employee records, including detailed payroll records, personnel files, employee wage scales, shift schedules, union contracts, agreements, fringe benefits (e.g., deferred compensation, pension plans, insurance, personal use of assets, special allowances), individual accounts of leave days, job descriptions, and payroll tax returns.
- Facility policy and procedure manuals and related materials.
- Plans for internal control.
- Minutes of meetings of the governing body.
- General and subsidiary ledgers, including stock ledgers, cash receipts, etc.
- Purchase requisitions and orders.
- Vouchers and invoices in detail to support services and goods purchased.
- Records related to management fees, executive services or personal services contracts, and contracts for services under arrangement.
- Charts of accounts.
- Checking account registers, canceled checks, and bank statements.
- Vehicle mileage and use logs.
- Fixed asset records.
- Capital expenditure records and depreciation lapse schedules.

- Copies of long-term debt obligations, mortgages, notes payable/receivable, amortization schedules, year-end statements, and loan histories.
- Tax returns, or federal informational returns for tax-exempt facilities.
- Provider organization ownership disclosure records, e.g., Articles of Incorporation, Partnership Agreement, and other similar documentation.
- Records regarding chain organizations, including corporate home office costs.
- Work papers and records regarding the preparation of cost reports.
- Audit reports of financial statements.
- Work papers of internal and external accountants used in the preparation of the cost report(s).
- Records regarding working capital.
- Leases and all related records.
- Accounts receivable Aging Schedule.
- Accounts payable Aging Schedule.

6.1.B. Availability of Information

The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by Medicaid auditors. MDCH audit staff or their designees will not complete an audit if the nursing facility does not make required information available. If the required information is not released within 15 days of a written request by an auditor during an audit, the MDCH may assess a financial penalty to the provider until the requested records are made available to the auditor. The MDCH will issue prior notice to the provider that they will assess the penalty equal to 20 percent of the facility's monthly Medicaid payments, effective in the first month following the expiration of the 15-day notice period. Waiver of the penalty assessment is only allowed by approval of the Medicaid Director following the provider's request for waiver consideration, including justification for the request and additional time to provide the records.

NOTE: A nursing facility provider that has been assessed a penalty is prohibited from collecting additional funds from Medicaid beneficiaries to compensate for the penalty.

If, after the 15-day period, the records become available for auditor review, an authorized representative of the nursing facility must give written notice of record availability to the MDCH Office of Audit. This acknowledgement to release the requested records must designate the contact person and record location. The payment penalty will be discontinued effective for the month following the date the auditor determines that the required records have been released and the dollar amount of penalty assessments will be refunded to the nursing facility provider. The auditor's determination that the requested records have been provided will be made within 60 days of such written agreement to release the requested records.

The auditor may determine that records necessary to verify specific cost report expenses are required to complete the audit. Failure to release the requested records within 15 days of a written request will result in a disallowance of costs associated with the item in question. If the nursing facility disagrees with the disallowance, this disallowance can be appealed at the completion of the audit. (Refer to the Appeal Process Section in this chapter for additional information.)

6.1.C. Retroactive Rate Changes

A retroactive change in a nursing facility's rate and reimbursement may be made after completion of an audit in the following situations:

- For those providers that are retrospectively settled.
- For those providers that had an interim rate set prior to completion of the cost report audit.
- For those providers that were retrospectively settled because they were granted Rate Relief.
- For audit adjustments required as a result of a hearing decision.

Refer to the Reimbursement Rate Determination section of this chapter for detail information regarding retroactive effective time periods for rate determination and reimbursement actions.

6.1.D. Reopening Audit Determinations

The MDCH may elect to reopen an audit determination following completion and closing of the audit of a nursing facility cost report. The MDCH will provide notice to the nursing facility of the audit reopening and the issues for which the audit is under review. Results of the audit reopening will be submitted to the provider, who will be given the opportunity to review the findings and appeal in accordance with Medicaid policy. If it is determined that the audit cost report contains incorrect data, the MDCH will use corrected data to compute future rates. The audit revisions will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning the month following notice to the provider that the subject audit is being reopened.

The results of audit reopening actions will only be effective for retroactive reimbursement revision in cases of fraud or when the provider's failure to disclose required information was pertinent to the determination of allowable cost.

6.1.E. Record Retention

Each nursing facility's accounting and related records must be kept for a period of not less than seven years. This obligation does not end if a provider closes or sells a facility. All records, source documents, contractual agreements, and corporate minutes must be available onsite, or at a readily accessible location, for verification and inspection by MDCH staff or their designees. When accounting personnel, books and records are located out of state, the provider is required to pay auditor travel expenses if MDCH staff

or their designees deem it necessary to access documentation during the course of an audit.

6.2 Financial Fraud and Abuse

Federal Medicaid law and regulations require the Medicaid program to establish and maintain methods and criteria for the identification, investigation, and referral of potential fraud and abuse. In accordance with federal and state requirements, the MDCH will authorize the suspension of Medicaid payments (in whole or in part) to a nursing facility provider on receipt of reliable evidence that the provider committed fraud or willful misrepresentation while enrolled as a Medicaid provider. The provider will receive written notice of such suspension and may request an administrative review. (Refer to the Appeal Process Section in this chapter for additional information.)

A MDCH auditor or designee that observes potential fraud or financial abuse will prepare a separate report of observations. Observations of potential fraud or abuse include, but are not limited to, the following:

- Recording of personal expenses.
- Overutilization of services to inflate charges.
- Unauthorized use of resident trust funds.
- Payroll entries of personnel who provide no services.
- Concealment of business activities.
- Falsifying records.
- Charging Medicaid for costs not incurred.
- Duplicate billing.
- Billing beneficiaries inappropriately for Medicaid services.
- Soliciting, offering, or receiving a kickback, bribe, or rebate.
- Abuse of internal accounting control.

Reports of observations will be reviewed by MDCH staff and appropriate actions taken. This may include forwarding a copy of the report and supporting documentation to the state Attorney General's Health Care Fraud Division.

SECTION 7 - COST REPORT REIMBURSEMENT SETTLEMENTS

The nursing facility reimbursement rate is determined in accordance with the policy provisions outlined in the Rate Determination Section of this Chapter. The reimbursement rate may include routine nursing care services and various rate add-on amounts depending on the Medicaid reimbursement policy effective at the time. The reimbursement rate is a per diem amount determined by the Provider Type. Rate determination may be based on filed cost report data, audited cost report data, cost data submissions and projections for specific reimbursement activity, or interim reimbursement provisions in accordance with Medicaid policies. The reimbursement rate is determined at the beginning of the rate year and the nursing facility is provided notice of the rate determination prior to implementation of the rate. The reimbursement rate may be revised any time during the rate year in accordance with rate determination policies. Rate revisions can result from the following actions as detailed in the Rate Determination Section:

- More recent Fiscal Year filed cost report
- Audited cost report
- Plant Cost Certification
- Nurse Aide Training and Competency Evaluation Program
- Special Dietary Cost Allowance
- Special Reimbursement policy actions

Reimbursement for ancillary services provided to Medicaid-eligible residents will be made in accordance with policies identified in the Nursing Facilities Coverage and Limitations Chapter of this manual, and the Institutional Billing and Payment Chapter of the Medicaid Provider Manual.

7.1 INTERIM REIMBURSEMENT AND RATE REVISIONS

The Rate Determination Section in this chapter outlines the process for determining the nursing facility's annual reimbursement rate. If RARSS determines that a reimbursement rate must be revised, the rate change may affect payment for future and/or previous dates of service. RARSS will notify the provider of the rate change and the rate's applicable time period.

If a rate revision applies to future dates of service, RARSS will send written notice to the provider's designated address specifying the revised rate and the applicable time period for the rate.

If a rate revision must be applied to previous dates of service in the current cost report year, RARSS will notify the provider of the applicable time period and the reimbursement rate. If the rate revision applies to previous dates of service in the current cost report year, RARSS will make the determination of an underpayment or overpayment amount, and RARSS will notify the provider of the process for implementing the payment adjustment(s).

If the rate revision applies to a prior cost report year's dates of service, the payment adjustment process is addressed in the Initial Settlement Section of this chapter.

7.2 Initial Settlement

The SMA may determine that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. The retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After the filing and acceptance of the cost report, the RARSS will determine if an Initial Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Initial Settlement uses the submitted cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. (Refer to the Rate Determination Section of this Chapter for additional information.)

The RARSS will consider provider requests for Initial Settlements on an exception basis in the following situations:

- The provider anticipates a significant amount due them by Medicaid and requests an Initial Settlement in writing. The provider may make the request with the filing of the cost report.
- A payment adjustment is necessary for several months of the cost report period, and the current date is beyond the cost report period end date.
- The review of a filed cost report identifies that the interim rate add-on amount, plant cost certification amount, or other special reimbursement interim amount included in the interim rate exceed the amounts filed in the cost report.
- The provider has terminated Medicaid participation and has failed to file an acceptable cost report. An overpayment determination will be made for the payments to the provider during the time period that cost report data is required for determining final reimbursement.

If the RARSS determines that the Initial Settlement is an underpayment amount to the nursing facility, additional payment will be made to the provider for not less than 70 percent and not more than 80 percent of the determined settlement amount due the provider based on a review of the provider's financial situation and the effect of the filed cost report data on the reimbursement settlement determination. Although the provider may request a review of the Initial Settlement amount, the Initial Settlement payment level percentage is not subject to appeal.

If RARSS determines there is an overpayment to the nursing facility, the SMA will recover the overpayment amount as outlined in the Medicaid Recovery of Overpayments subsection.

Before making any payment adjustment, the RARSS will notify the provider in advance using a Notice of Program Reimbursement letter. The provider is given 15 calendar days for review of the settlement determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider. A provider may request up to an additional 30 days to review an Initial Settlement. The provider must submit a written request stating the reason and the amount of the additional time needed (up to 30 days) for review. RARSS will review the request and notify the provider in writing of the approval or denial for additional time

If the settlement action requires correction following the review, a new notification and review time period will apply to the corrected settlement. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is mailed to the provider.

The RARSS may process a Revised Initial Settlement for the cost report period if it determines that additional payment adjustment is necessary after processing an original Initial Settlement and before completing a final settlement. A revised initial Settlement will be completed when there are significantly more approved claims, rate revisions or errors in the prior determination and a final settlement action cannot yet be completed. The notification and payment processing actions identified with the original Initial Settlement procedures also apply to the Revised Initial Settlement process. The payment criteria will be applicable to the aggregate dollar amount of the Initial and Revised Settlements for the reimbursement time period.

7.3 Final Settlement

The RARSS may determine that withholding of payment is necessary or that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. A retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After a cost report is audited, RARSS will determine if a Final Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Final Settlement uses the submitted cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. Final Settlements determine if additional payment is due to the nursing facility, or Medicaid.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

RARSS mails a Notice of Program Reimbursement to the provider's designated address. The notice explains the:

- Settlement adjustment(s) and the process prior to RARSS taking the payment action.
- Provider's appeal rights.

The provider is allowed 15 calendar days for review of the settlement determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider.

To obtain an extension, RARSS will review written requests from the provider stating the exceptional reason and the amount of additional time needed for the review (up to 30 days). RARSS will review the exceptional circumstances stated in the request and notify the provider in writing of the approval or denial for additional time. If approved, an extended time period of up to an additional 30 days may be granted to the provider for review. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is mailed to the provider.

If the settlement action is corrected following a review, a new notification and review time period will apply to the revised determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider.

RARSS may process a Revised Final Settlement for the cost report period if RARSS determines that additional adjustments are necessary subsequent to processing the Final Settlement. The adjustment(s) will be processed if significant adjustments or errors exist in the prior settlement calculation. Notification and payment processes outlined in the Final Settlement process also apply to the Revised Final Settlement process.

7.4 Depreciation Recapture Reimbursement Adjustment

If a provider has been reimbursed for asset depreciation expense in the Plant Cost Component and has sold the nursing facility assets, the sold assets may be subject to a depreciation recapture reimbursement adjustment in the reimbursement settlement for the cost report period in which the nursing facility assets are sold. The depreciation reimbursement adjustment uses reimbursement rates paid for services between October 1, 1984 and the date the facility was sold, or the date the Plant Cost Component of the per diem rate was converted to the tenure plant cost reimbursement method. (Refer to the Rate Determination Section of this Chapter for additional information.)

The depreciation recapture adjustment is only applicable to the reimbursement rate time periods the provider was paid a rate that specifically included depreciation expense in the Plant Cost Component of the Medicaid per diem rate. If the provider has never received Plant Cost Component reimbursement that specifically includes depreciation expense as a cost element of the rate calculations, the provider is not subject to the depreciation recapture reimbursement adjustment and is not required to complete the Medicaid Program Depreciation Recapture reporting.

A nursing facility provider that was reimbursed for depreciation in the Plant Cost Component and sells the nursing facility's assets must complete the Medicaid Program Depreciation Recapture reporting schedules for each applicable cost reporting year where depreciation was reimbursed. The Medicaid Program Depreciation Recapture schedule must be submitted with the cost report for the year that the asset sale occurs. Reporting schedules and instructions will be provided to the Provider with the final period cost reporting request or may be requested from RARSS. The reporting schedules (Excel file) and completion instructions (Word file) are available in electronic format or hard copy format.

If the Medicaid Program Depreciation Recapture is not applicable, the schedules must indicate N/A (not applicable) and be submitted with the cost report filing. If RARSS does not receive completed reporting schedules, RARSS will apply a 100 percent depreciation expense reduction rate to calculations for each cost report period used to calculate the settlement.

The net depreciation reimbursement adjustment for each cost report year the provider was reimbursed by Medicaid will be included in the settlement calculation. The depreciation adjustment will be limited to the amount Medicaid reimbursed for depreciation expense in each cost report year. Plant cost reimbursement allowances will be included in the calculation of the depreciation adjustment, and may result in reducing the net depreciation adjustment if the provider had not previously qualified for the incentive allowances prior to the depreciation reduction. The cost report reimbursement settlement notice will include the determination of depreciation recapture reimbursement adjustment.

7.5 Medicaid Recovery of Overpayments

Overpayment(s) due from a participating provider will first be offset against other settlements, payment adjustments, claims processing or any amounts due to the provider through lump sum or sequential installments until the overpayment amount is satisfied. If the provider is not participating in Medicaid, the overpayment amount must be paid to the State of Michigan for the Medicaid program immediately upon notification.

7.5.A. Request for Settlement Extended Payment of Schedule

If a participating provider alleges inability to repay the total overpayment amount in a lump sum or in sequential offset(s), the provider may request consideration for an extended repayment schedule. Extension requests for Settlement repayments must be received by RARSS within 15 days of the Notice of Program Reimbursement date sent to the provider from RARSS. RARSS will notify the provider in writing of the decision. Requests received after 15 days will be considered at the discretion of RARSS.

7.5.B. Criteria for Determining Extended Payment Arrangements

Extended settlement repayment schedules will only be considered if the net dollar amount of the current settlement notice reflects an overpayment amount of more than 10 percent of the provider's normal monthly Medicaid reimbursement payment(s). The provider's request must demonstrate that lump-sum recovery will create extraordinary financial hardship on the provider, and that the cash flow need of the nursing facility prevents the immediate repayment of the overpayment amount. Other factors that must not be present in creating financial hardship to the provider are significant expenditures for unallowable costs, ownership and management compensation exceeding Medicaid allowable cost limits, or significant dollar amounts for unallowable related party business transactions.

RARSS will mail the notification of the provider's repayment schedule and the repayment recovery dates and dollar amounts to the designated address. Requests for longer than three months will only be considered under exceptional circumstances e.g, the monthly recovery schedule amount would be greater than 50 percent of the provider's normal monthly Medicaid reimbursement payment.

SECTION 8 - ALLOWABLE AND NON-ALLOWABLE COSTS

Unless stated to the contrary in this section, Medicaid allowable costs for nursing facilities are determined in accordance with provisions in the federal Principles of Reimbursement established for the Medicare program. Reasonable costs associated with nursing facility services included in the provider's per diem rate, as identified in the Coverages and Limitations Chapter of this manual, are allowable costs within the parameters of the Principles.

NOTE: Definitions for the principal terms used in this section may be found in the Definitions Section of this chapter. A copy of the cost report referenced in this section, completion instructions for the report and related information are available on the Michigan Department of Community Health (MDCH) web site. (Refer to the Directory Appendix for website information.)

8.1 ADVERTISING

Allowable advertising costs are considered those costs incurred by the nursing facility for an informational objective to inform the public about its services. Costs incurred for a promotional objective in an attempt to increase patient utilization are not properly related to patient care and are not allowable. Advertising in the Yellow Pages is an allowable cost, except that Medicaid limits the cost to that associated with a black ink Yellow Pages ad listing not to exceed 2" x 2" in size.

8.2 APPRAISALS

Appraisal expenses incurred by providers may be allowable costs (administrative and general) if the appraisal is of assets related to resident care and if it meets the Medicaid's Appraisal Guidelines. Expense for an appraisal of assets not related to resident care is not an allowable expense. The Appraisal Guidelines (Attachment A) appear in the Nursing Facilities Reimbursement Appendix.

8.3 ATTORNEY AND LEGAL FEES

The provider must maintain documentation and evidence of expenses incurred for legal fees and related costs as being related to the nursing facility's furnishing of patient care in order for such expenses to be allowable costs. Attorney fees incurred in the normal course of nursing facility business, to provide representation to a provider in an audit or rate setting action, or representation in patient care related matters might be considered allowable costs. Legal fees for defense against charges of fraud or for other actions are only allowable in cases where the provider or provider representative prevails and is exonerated from wrongdoing. Legal expenses associated with any action initiated by the nursing facility are not allowable if there is no reasonable legal ground for the institution of such action.

Legal expenses incurred by the nursing facility in defense of an exclusion of participation or civil money penalty assessment under Medicare or Medicaid enforcement action are unallowable costs if there is no reasonable legal ground for the nursing facility's case. Medicaid defines there is no reasonable legal ground/basis in such cases where the determination of non-compliance by the nursing facility is upheld and/or the total enforcement action has not been rescinded.

Attorney fees or similar costs (e.g. recording costs), transfer taxes and service charges (including finder's fees and placement fees), incurred in connection with facility acquisition, mortgage or finance transactions are allowable if the fees are determined reasonable by Medicaid and the fees must be reported under plant cost and capital asset cost reporting. Legal expenses incurred relative to a nursing

facility or capital asset acquisition are considered costs of the capital asset acquisition and must be included in the capital cost of the asset for Medicaid cost reporting. Legal fees incurred in the process of securing financing or refinancing of facility loans must be amortized over the life of the mortgage.

8.4 Bad Debts, Charity and Courtesy Allowances

Bad debts, charity, and courtesy allowances, as defined in the Medicare Principles, are deductions from revenue and are not allowable costs.

Bad debts are amounts considered to be un-collectable from accounts and notes receivable that were created or acquired in providing services. Charity allowances are reductions in charges made by the nursing facility provider due to the indigence of a resident. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the nursing facility, for services received by the provider.

Uncollected revenue for Medicare co-insurance and deductible billing amounts and patient payments for Medicaid eligible residents, and for non-covered services for Medicaid are not allowable costs.

8.5 Civil Money Penalties

Costs incurred for fines or money penalties for violation of federal, state, or local laws are not allowable.

8.6 Educational Activities

The net allowable cost of educational activities is determined in accordance with Medicare Principles of Reimbursement except that all costs of educational activities outside the continental United States are not allowable.

Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues received from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities.

Approved educational activities are formally organized or planned programs of study engaged in by nursing facility providers in order to enhance the quality of resident care in a facility. These activities must be licensed where required by state law. Where licensing is not required, the organization presenting the educational activity must receive approval from the recognized national professional organization for the particular activity (e.g., National Association of Nursing).

The costs of the following activities are not within the scope of educational activities but are recognized as routine nursing care costs and are allowable costs:

- Orientation and on-the-job-training.
- Part-time education for a facility's employee at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work to enhance the quality of medical care or the operating efficiency of the nursing facility.
- Costs, including associated travel expense within the continental United States, for employees to participate in educational seminars and workshops to enhance the quality of medical care or the operating efficiency of the nursing facility that does not lead to the ability to practice and begin employment in a nursing or allied health specialty.

- Maintenance of a medical library.
- Training of a resident or resident's family in the use of medical appliances.

Costs incurred for activities related to an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) are not allowed under routine nursing care, except as provided in the Medicaid allowable cost and reimbursement policy outlined in the Cost Classifications and Cost Finding Section of this chapter.

8.7 Facility Vehicles and Travel

The cost of operating a facility-owned or leased vehicle must be adequately documented and differentiated between resident care, business use or personal use. Only the costs for resident care and costs related to the conducting of facility business are allowable vehicle and travel costs. Use of a facility vehicle by facility personnel to commute from home to the facility and to return home at the end of the daily work period or other personal travel activity is considered personal use. Cost related to personal use travel activity is generally not allowable. Vehicle personal use costs are only allowable if the costs are considered employee compensation and meet the financial reporting requirements under Internal Revenue Service.

The minimum documentation that must be retained for all vehicles is:

- Mileage logs or similar types of records for each vehicle.
  - The log must contain at least the date, beginning and ending odometer readings for each trip, name of driver, destination, and reason(s) for the trip.
  - Each log must report total monthly miles traveled.
- Business mileage and total mileage for the trip to support a dollar allocation.
- Charge slips or invoices for fuel, maintenance, and other similar items.

If the reason for a trip is to transport a resident for medical care or treatment, the medical condition necessitating the trip must be documented. If the reason is to attend a seminar, convention, or meeting is related to nursing facility operation, invoices must document proof of attendance and mileage logs must be documented to identify the reason for the trip. Vehicle use for general business travel or other activity must include the reason in the mileage log.

Medicaid considers mileage that is not logged as not related to resident care or facility operation, and the cost relating to unlogged mileage is not allowable.

Travel by nursing facility personnel via personal vehicle use is an allowable expense if the travel is consistent with the aforementioned purpose criteria. Medicaid will allow such documented mileage at the State of Michigan, Department of Management and Budget (MDMB), approved private vehicle rate. The mileage rate includes all vehicle costs and is treated as a variable support cost. The approved private vehicle mileage rate information can be accessed on the MDMB website at www.michigan.gov/dmb, click on Agency Services, Travel, Travel Rates.

8.8 INTEREST

Interest is the cost incurred for the use of borrowed funds. Necessary and proper interest on both current and capital indebtedness is an allowable cost in accordance with Medicare Principles of Reimbursement. The allowance for interest expense is determined using one of the following principles.

Allowable interest expense for all other facilities is determined in accordance with current Medicare Principles. Medicaid applies the following guidelines, although not fully inclusive, in determining allowable interest expense.

- Interest expense must be reduced by all investment income, except where such income is from:
  - Gifts, grants, and endowments held separately or pooled with other funds.
  - Qualifying income from funded depreciation.
  - Income from a provider's qualified pension fund.
  - Qualifying deferred compensation and/or self-insurance trust funds.
- The rate of interest on a loan must not be in excess of what a prudent borrower would have had to pay in the market place existing at the time the loan was made.
- Interest expense, to be allowable, must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. Interest paid by the provider to partners, stockholders, or related organizations of the provider is, therefore, not allowable.
  - **Exception:** A nursing facility operated by a religious order is allowed to borrow funds from the order and claim necessary interest expense for those funds.
- Interest on loans in excess of asset value acquisitions (after July 1970) is not an allowable cost. In a situation where the purchase price exceeds the historical cost or the cost basis, the interest expense on that portion of the loan used to finance the excess is not allowable.
- Interest expense applicable to borrowings principle balance for a nursing facility acquisition must be separately identified and reported from interest expense applicable to working capital or miscellaneous capital asset acquisitions (assets that are not part of or related to a facility acquisition). See Cost Finding and Cost Classifications for borrowing principle balance descriptions.
- Working capital borrowings are considered funds borrowed for a relatively short time period to meet current normal operating expenses. Interest on current indebtedness - loan amounts repaid within twelve months - is allowable, whereas interest expense for long-term working capital indebtedness is not considered allowable.
- Interest income is applied first as a reduction to mortgage related borrowing allowable interest expense, and then to other borrowings allowable interest expense.
- Interest expense is distinguished from penalty or finance late fees by the existence of a lender and borrower relationship pertaining to the financed amount. Penalty and finance fee assessments relating to late payment of liabilities are not considered borrowing costs and are not allowable.

8.8.A. Interest

For the Class I and Class II facility, interest on borrowed funds related to the facility acquisition allowable interest expense is determined in accordance with the Principles in effect on July 17, 1984, prior to the changes associated with the mandates of the DEFRA of 1984 and its limitations on the revaluation of assets.

- The dollar amount of facility acquisition financing is limited to the lesser of a) the purchase price of the nursing facility, b) the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or c) fair market value at the time of purchase; minus the purchase down payment.
- Interest expense on the dollar amount of a facility acquisition loan principle in excess of the financing limit is not allowable.
- Depreciated replacement cost is defined as the current reproduction cost adjusted for straight-line depreciation over the life of the asset.
- Depreciated replacement cost must be determined by an independent appraiser, chosen and paid for by the nursing facility provider, in accordance with the "Appraisal Guidelines" in the Principles.

Exception: A facility that chooses to forego increased reimbursement for interest expense as a result of the requirements in the Rate Determination section must report, as an allowable cost, the interest expense schedule of borrowings, principal amortization, and interest expense recognized for reimbursement by the Medicaid program prior to the sale.

8.9 Lease Costs

The Medicaid allowable cost provisions for asset lease transactions depend on the type of asset. Generally asset lease transactions require that the lease expense be removed from cost and replaced by the underlying ownership cost of the property owner. Lease or long-term rental agreement (more than twelve months duration) transactions must be reported in the Medicaid cost report Statement of Leased Capital Assets. Cost reporting disclosure of lease costs is required to properly classify ownership costs for determining Medicaid reimbursement. There are also specific asset lease transactions that must be reported in the cost report statement, but are exception to the underlying ownership disclosure requirement. Specific types of lease expenses are discussed in the following sections.

Maintenance costs for leased capital assets, other than lease situations qualifying under "pass-through lease" criteria, are classified as variable costs. The nursing facility must determine and report these costs in the appropriate cost center or department. This requirement may necessitate the breakout of the maintenance costs for the lease contract.

Lease costs are differentiated from incidental or non-recurring rental expenses incurred to address a limited need of the facility. Rental expense incurred for incidental or limited time rental items, or non-recurring rental transactions are allowable operating costs in the applicable cost center or department requiring the rental action. Limited time rental is considered as not longer than twelve months, non-recurring, and prohibits several/numerous sequential transactions for the same or similar rental items.

8.9.A. Facility Lease

Cost reporting and reimbursement for capital assets relating to the nursing facility premises are under the same methods whether the items are owned or leased. For items to be considered allowable costs, the acquisition dates and asset costs, interest expense and other applicable ownership costs must be reported. Allowable lease costs are determined using one of the following principles:

- A nursing facility provider that entered into an acceptable, arm's-length lease prior to September 1, 1973, where the lessor has refused to open its books, is allowed an actual lease cost up to a maximum of $2.50 per resident day. This limit was developed from the average lease/rental costs for facilities leased prior to September 1, 1973, at which time the current method of calculation was effected. The pre- September 1, 1973, lessee has the right of appeal of an acceptable, arm's-length lease agreements for costs that exceed the $2.50 limit.
- A nursing facility provider that entered into, or amended, an acceptable, arm's-length lease agreement on or after September 1, 1973, is allowed a plant cost component determined in accordance with the Rate Determination section of this chapter, as applicable to an owner-provider, if the lessee discloses the allowable cost information required for rate setting. Leased assets are treated as though the lessor and the lessee are one and the same. Without full disclosure, lease expenses are not an allowable cost.

Interest expense allowed in the case of the lessor is also limited by Medicare Principles of Reimbursement. Further, interest income of the provider (lessee) is offset against all interest expense including interest expense allowed on rental properties.

8.9.B. Plant Cost Lease Other Than Facility Space

Lease expense for nursing facility equipment or other activity that does not qualify for pass through lease expense is not allowable and must be reported utilizing the ownership underlying cost reporting requirement. If a lease is a virtual purchase and the lessee becomes the property owner at the termination of the lease, or for a nominal buyout amount, ownership cost reporting must be applied. The definition criteria of a virtual purchase are addressed in the federal Principles of Reimbursement.

Office space costs incurred in a home office or related party administrative service transaction is allowable under application of allowable depreciation, interest and property tax underlying ownership cost principles. Reasonable and necessary lease expenses incurred by a home office or related party for administrative services office space are allowable. Ownership underlying cost reporting is not required for leased business office space or similar leased space except in rental transactions involving a related party landlord. Related party transactions for office space is limited to ownership underlying costs applicable to allowable depreciation cost principles. The cost of office space is included in the cost of the home office or related party administrative services space cost and must be reported in accordance with Medicaid policy identified in the Cost Classification and Cost Finding Section of this chapter.

8.9.C. Plant Cost Pass Through Leases

A select group of rental and lease situations are exception to the requirement for disclosure of the underlying ownership costs. The lease or rental cost of qualifying items is allowed as plant cost in the lease rental cost classification to the extent that the asset use and cost is related to patient care. The pass through lease allowance applies to the following:

- Vehicle lease to a maximum of $425/month or $5,100/year, per vehicle
- Photocopiers
- Postage meters
- Telecommunications systems (including FAX machines)
- Desktop or notebook computers and printers
- Parking lots and off-site record storage for rental from an unrelated party ownership and arm's length transaction

8.10. Life Insurance Premiums

Life insurance premiums are allowable when the premium is a fringe benefit for the insured employee, when the beneficiary of the employee's insurance is not the provider. The cost of life insurance premiums for insurance on the lives of officers and employees, including provider-based physicians, is an allowable cost only within the provisions of Medicare Principles of Reimbursement.

8.11 Liquidation of Short-Term Liabilities

A short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The liquidation of liabilities requirement for Medicaid applies the federal Principles of Reimbursement for the determination of allowable costs. In instances where a nursing facility provider does not liquidate a short-term liability within the period specified in the federal requirements, the costs for the related goods and services is not allowed in the cost reporting period in which the liability was incurred, but is allowable in the cost report period when the liability is paid.

Exception to the one-year time limit to liquidate a short-term liability will be considered in accordance with the federal Principles of Reimbursement. A provider may request an extension for good cause to liquidate short-term liability. The provider must submit a written request at the time of submission of the Medicaid cost report to RARRS identifying the liability amount(s) and an explanation for the nonpayment of the liabilities and expected payments to liquidate the liability. RARRS will review the request and notify the Provider of the approval of an extension, not to exceed 3 years after the end of the cost report period that the request is filed, or of the denial of the request.

8.12 Lobbying and Political Activity Costs

A provider's costs incurred to support or oppose decisions of the federal Congress or state Legislature, costs related to campaigns for particular candidates or issues, and contributions to political action committees involving partisan elections are not allowable. Costs incurred, whether directly or indirectly through organization membership dues, fees or assessments, for these activities or to influence

legislation are not allowable. Contacts with federal or state agencies in the course of business operations of the nursing facility and general comment on proposed policies are not considered lobbying activity.

8.13 Maintenance Of Effort Contributions by County Government

In accordance with Public Act 408 of 1984, as amended, county governments that own and operate a nursing facility are responsible for maintenance of effort funding levels for the operation of the county owned and operated nursing facility. The county government contributions to the nursing facility operations specifically due to the provisions of the Act, as amended, are not allowable costs of the county medical care facility Medicaid cost reporting.

8.14 Membership Fees

Reasonable costs of memberships in professional, technical, or business-related organizations are allowable if the organization's mission or objectives are primarily related to resident care and/or long term care services activities. Costs of memberships in civic organizations for the purpose of implementing civic objectives are also allowable for Medicaid purposes (e.g., Chamber of Commerce). Any portion of membership fees used for lobbying, supporting political candidates and campaigning, or in social, fraternal, and other such organizations are not allowable. Awareness of an organization's ongoing lobbying and political activities requires identification of the portion of the organization's fees, dues, assessments or other allocations of costs to members or associated nursing facility providers. If an amount of non-allowable cost is not identified relating to this purpose, all costs associated with the fees or dues are non-allowable, unless the provider can document the appropriate unallowable portion.

8.15 Medical Director/Physician Services

The nursing facility must have a designated medical director that maintains responsibility for the implementation of resident care policies, for coordinating medical care, and is directly accountable to nursing facility management. The cost(s) applicable to the provision of the duties and responsibilities of the medical director are allowable routine nursing care. The nursing facility must maintain adequate records to document the level and type of services rendered by the medical director as a facility employee, or under a service contract, or some other designated capacity. The cost(s) relating to the medical director duties and responsibilities must be distinguished from physician services activities that are not allowable routine nursing care. Refer to the Medicaid Provider Manual, Nursing Facilities section, for discussion regarding physician services.

8.16 Non-Paid Workers/Volunteers

The value of services of non-paid workers is an allowable cost. The services must be performed on a regular, scheduled basis. The services must be of the type customarily performed by full-time employees and necessary to enable the nursing facility provider to carry out the functions of normal resident care and the operation of the facility. The value of services of a type for which providers generally do not remunerate individuals performing such services is not an allowable cost.

Example: Donated services of individuals in distributing books and magazines to residents, administering a provider canteen or cafeteria or a provider gift shop are not allowable/reimbursable.

8.17 Owner and Administrator Compensation

The cost for compensation to nursing facility owners is determined in accordance with Medicare Principles of Reimbursement, except the compensation to administrators, owner/administrators, or owners who function as administrators or assistant administrators, and corporate office executive management compensation is subject to specific dollar amount cost limits. Allowable cost limits are applied to nursing facilityies based upon the bed size of the facility. Allowable cost limits are applied to individuals based upon the aggregate number of beds in nursing facilities being served or within the corporate organization. Compensation is remuneration to the individual for job performance and includes the costs of salary and wages, fringe benefits, director fees, and costs of services or items provided to the individual.

8.17.A Compensation Limit for Individual Nursing Facility

The allowable cost limit for compensation to nursing facility administrators, owner/administrators, or owners who function as administrators or assistant administrators is determined according to the following criteria.

- Facility bed size includes licensed beds for nursing home, home for the aged and hospital services beds. Other categories of resident beds or housing arrangement beds are not included in determining the facility bed size for determining the appropriate compensation limit.
- The owner/administrator compensation limit used must coincide with the number of beds available for occupancy. The measurement criteria for determining the facility bed size is the number of beds available for resident or patient care at the beginning of the cost reporting period.
- Each nursing facility having 50 licensed beds or more must have a full-time licensed facility administrator. As required under State law, this individual is expected to be in the facility directing, conducting, or participating in activities directly related to the nursing facility during the normal 40-hour business week. A current position description that adequately defines the duties and responsibilities for the administrator position must be retained at the facility.
- The total compensation amount claimed for allowable costs for the facility administrator and related positions must not exceed amounts established by the State Medicaid Agency. These amounts are established by facility bed size: 1-49 beds, 50-99 beds, 100-149 beds and 150 beds or more. Owner/Administrator Compensation Limits are expressed as facility annual compensation amounts and must be pro-rated on a monthly basis in situations where the cost reporting time period is not twelve months. The compensation limit schedule is available on the MDCH web site. MDCH annually adjusts the Owner/Administrator Compensation Limits to include cost-of-living changes as reflected by the United States Department of Labor Consumer Price Index for the metropolitan Detroit area. (Refer to the Directory Appendix for the web site address.)

The owner/administrator compensation limits apply to the costs for the positions of administrator, assistant administrator, and/or other administrative employees performing functions or having work responsibilities normally considered nursing facility administrator work activity. If an individual is functioning in a position that requires a nursing facility administrator's license, that person's compensation must be subjected to

the limit. However, if a person does not have a license, but is performing the job functions and work activity of an administrator, that individual's compensation must also be included in the amount subjected to the limit. Inclusion of an individual's compensation in the total amount subjected to the limit is not only based on the individual having a license; it is also based on the job functions and work activity. Compensation paid by a related party or central office and charged directly to the nursing facility for individuals performing these activities must be included in the individual nursing facility compensation amount subjected to the limit.

The compensation limit schedule does not apply to the salary of owners employed in capacities other than administration of the nursing facility provider's operation. The allowable salary level of an owner employed in a non-administration position cannot exceed the market value salary for that position, e.g., director of nursing, social services director. The allowable salary level must be commensurate with the amount of time the owner spends working in the non-administration position. If the owner also participates in facility administration, the portion of the payroll costs attributed to the administrative work must be included in the owner/administrator salary compensation and subject to the appropriate salary limits. The individual's administrative work must be appropriately documented with a position description and job responsibilities, and the allowable salary level for the administrative work must not exceed salary levels for similar administrative positions.

8.17.B Compensation Limit for Owner and/or Administrator Serving Multiple Nursing Facilities

Where an individual is involved in the administration of more than one nursing facility, the maximum compensation allowed for allocation per facility and the allowable facility compensation is computed as follows:

- Total the number of beds, as defined in the individual nursing facility section, in all facilities served by the owner and/or administrator.
- Determine the appropriate compensation limit from the published schedule for the total number of beds.
- Compare the appropriate compensation limit with the actual allowable total salary and fringe benefits paid to the individual. The compensation limit is expressed as an annual amount (12 months time period) and applicable to a full time position defined as a minimum of 40 hours per week committed to nursing home related management and administrative activity. Adequate work activity records must be available for verification of time expended for nursing facility related activity. Time commitment for less than full time requires the compensation limit be prorated to reflect the portion of time committed to this activity. Example, if 30 hours per week during an annual period is attributed to this activity, the adjusted limit for the individual is 75 percent of the appropriate compensation limit.
- The lesser of total allowable compensation or the compensation limit per the schedule is then allocated to all the facilities served by the owner and/or administrator based on a ratio of the number of beds in the individual facility to the total number of beds in all facilities served. The hours directly devoted to individual homes may be used as the allocation basis if verified by auditable records.

- Combine the allocated owner and/ or administrator compensation with the allowable compensation of the facility's administrator/assistant administrator/co-administrator.
- Compare the combined compensation amount to the compensation limit schedule maximum allowable for the number of beds for that particular sized facility. The lesser of the facility's combined compensation or the facility's compensation limit is the allowable compensation to be used in the determination of allowable cost related to resident care.

The following illustrates an example of the allowable owner/administration compensation limit application for a group of four facilities of varying sizes with a total of 400 beds, and the allowable facility compensation. The owner and/or administrator total compensation is $225,000 for full time nursing facility related activity for a cost reporting period ending December 31, 2003. The compensation is $48,914 greater than the limit ($225,000 minus $176,086 equals $48,914).

Total number of beds in all facilities served	330
Compensation Cost Limit for 150+ bed facility as of 12/31/2003	$176,086
Owner and/or Administrator Total Compensation	$225,000
Amount allowed for allocation to individual facilities (lesser of bed size limit or actual compensation	$176,086
Amount of compensation not allowed	$48,914

Nursing Facility Bed Sizes	1-49 Beds	50-99 Beds	100-149 Beds	150+ Beds
Facility Compensation Limit 12/31/2003	$58,696	$97,826	$117,393	$176,086
Example Facilities	Facility 1	Facility 2	Facility 3	Facility 4
Total Facility Beds	40	70	100	120
Allocation of Owner and/or Administrator Compensation (1)	$17,609	$30,815	$44,021	$83,641
Compensation of Facility Administrator	$35,000	$75,000	$85,000	$100,000
Facility Total Compensation to be compared to Limit (2)	$52,609	$105,815	$129,021	$183,641
Disallowed Compensation per Facility	$0	$7,989	$11,628	$7,555

- The percentage of the facility's beds of the total across all four facilities is multiplied by the compensation limit, e.g., 40/330 x $176,086.
- Total compensation equals the sum of the allocation amount and the individual nursing facility administrator compensation.

8.17.C. Compensation Limitation For Home Office Executive/Management

Salary and wages, fringe benefits and other related compensation costs for home office executive and management staff are included in the provider's home office cost report and costs are allocated to the individual nursing homes and other business activities

conducted by the organization. The allocation of the compensation costs is made to the operating entities of the corporation through the home office cost statement and these costs are not included in the limit imposed on the individual nursing facility owner/administrator compensation.

The compensation limit for high-level management employees at the corporate home office level is enhanced to acknowledge increased scope of the business activity and corporate responsibility. The enhanced compensation limit is applicable in chain organization or related party management services situations where home office cost statement reporting exists, and full management oversight and administrative services are being provided to the nursing facilities and other business activities of the organization. Compensation costs for corporate office individuals under the enhanced compensation limit must be documented by a current position description, employment contract or other verifiable documentation that adequately defines the position, duties and responsibilities for the individual and demonstrates the presence of services provided to the organization. Compensation to an individual employee of the corporate or central office regardless of employment position or job activity function is subjected to the enhanced compensation limit to determine allowable cost. The enhanced compensation limit is expressed as an annual amount (12 month time period) and is applicable to a full time position.

Employees paid by the corporate or central office but charged directly to the individual nursing facility for administrator or assistant administrator work functions at that facility are not eligible for the enhanced compensation limit. Allowable cost limits for such employees are addressed under individual nursing facility compensation limit.

The enhanced Medicaid allowable compensation for individual corporate office official and executive management employee personnel is applicable only to organizations greater than 150 beds. The enhanced compensation limit is based on the total number of beds owned and operated by and under full management control of the corporate organization and determined in accordance with the following schedule:

Number of beds in the chain organization	Enhanced compensation limit
151 to 500 beds	100% of the 150+ bed facility limit
501 to 1000 beds	120% of the 150+ bed facility limit
1001 to 2000 beds	130% of the 150+ bed facility limit
Over 2000 beds	150% of the 150+ bed facility limit

The total number of beds includes all types of nursing home, home for the aged, hospital services, resident and other housing arrangement beds. If the business activity for the beds is not included in the allocation of the home office costs, the beds must not be counted for determining the number of beds in the chain organization. The 150+ bed facility limit used to determine the enhanced compensation limit amount is the MDCH published limit for the year end corresponding to the reporting time period end date of the home office cost statement.

8.18 Oxygen

Medicaid coverage of oxygen services for residents in nursing facilities is addressed in the Medicaid Services Descriptions Section of the Nursing Facilities Coverages and Limitations Chapter. The costs of oxygen gas, equipment, and supplies for intermittent and infrequent use are allowable in the routine nursing care cost and are included in the per diem reimbursement rate. Oxygen equipment rental costs for a limited time period for purposes of providing this service is allowable in accordance with the incidental rental cost provisions addressed in the Lease Cost subsection of this chapter.

The costs of oxygen related services for frequent or prolonged use by individual nursing facility residents, regardless of payer source, is an ancillary services cost and is not an allowable routine nursing care cost. These costs must be separately identified in the facility's accounting records or adequately compiled and verifiable for audit, and excluded from Medicaid cost report routine nursing care unit cost.

8.19 Patient Transportation

The Transportation Section of the Nursing Facility Coverages and Limitations Chapter addresses the nursing facility's responsibility to arrange or provide for non-emergency patient transportation. The cost for this transportation is a routine nursing care cost included in the nursing facility annual cost report and any reimbursement for the services is included in the routine nursing care per diem rate. Patient transportation costs are classified as support costs for Medicaid cost reporting.

The nursing facility is encouraged to utilize an efficient and cost effective mode of transportation for resident care, which may include utilizing a facility owned vehicle or contracted outside service. Costs relating to the nursing facility vehicle operation are addressed under the Facility Vehicles and Capital Asset Cost subsections of this chapter.

Cost incurred for contracted outside service for patient transportation must be included in the Medicaid cost reporting under the following reporting procedures:

- Administration and General Transportation – when the expense is not directly identified for specific residents or the care unit in which the resident resides in the facility, or
- Routine Nursing Care, Miscellaneous Support Cost – a) when there is only one routine nursing care unit in the facility and all resident transportation is for residents in that unit, or b) when there are multiple nursing or residential care units in the facility, and the expense is directly identified by individual resident and location unit where the individual resides in the facility. Costs classified in item b) must be to the corresponding nursing unit cost center identified in the Medicaid cost report.

8.20 Private Duty Nurses

Costs for nursing staff services provided by or under the supervision of a registered professional nurse is allowable, however, the cost of services of a private-duty nurse or other private-duty attendant are not allowable routine nursing care. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient under arrangement between the patient and the private-duty nurse or attendant.

A patient, or someone acting on their behalf, may arrange and pay for a private-duty nurse, or the nursing facility that initially incurs the requested costs may look to the patient for payment of the non-covered nursing facility service. Where the nursing facility acts on behalf of the resident, the services of the private-duty nurse or other attendant(s) under this arrangement are not allowable routine nursing care services regardless of the payment process to the private duty or other personnel or the control which the nursing facility may exercise with respect to the services rendered by the private-duty nurse or attendant.

8.21 Purchase Discounts

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Purchase discounts have been classified as cash, trade, or quantity. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. In addition, late charges on purchases are not an allowable expense. These would be in addition to regular costs authorized.

8.22 Rebates Larger than One Year's Expense and Extraordinary Expense

Normal refund or rebate amounts are reported as reduction offset to current operating costs in accordance with federal Principles of Reimbursement. A refund or rebate amount of previous years' allowable expenses must not be reported in total in the current fiscal year-end cost report where the refund or rebate amount pertains to more than one prior year reported expense. Likewise, extraordinary expense pertaining to more than one prior year must not be reported in total in the current fiscal year-end cost report. Refund or rebate and the extraordinary expense amounts pertaining to more than one prior year must be equally spread over as many subsequent years as the number of years represented by the refund or rebate or the extraordinary expense amount. The apportionment will start in the cost-reporting year in which the refund amount is received or the extraordinary expense is discovered. These provisions are limited to Medicaid cost reporting requirements and do not change the applicable accounting principles for financial reporting.

8.23 Research Activities

The cost of research activities is allowable in accordance with Medicare Principles. If research is conducted in conjunction with and as a part of the care of residents, the costs of usual resident care are allowable to the extent that such costs are not met by funds provided for the research.

8.24 Routine Nursing Services

A provider's costs associated with the provision of necessary medical, nursing and mental health services, within the provisions of Medicare Principles of Reimbursement and requirements specified in the Coverages and Limitations chapter of this manual, are allowable expenses. This includes costs incurred for meeting federal requirements associated with specialized mental health rehabilitation services, e.g., monitoring the necessity for Annual Resident Reviews and coordinating or providing required services.

8.25 Sick Leave

The reasonable cost of sick leave taken (or payment in lieu of sick leave taken) by an employee is recognized as a fringe benefit and is included in allowable costs in the cost reporting period when paid. If the sick leave is vested and refunded, contributions to the fund are allowed under applicable provisions of the Medicare Principles. However, where the nursing facility provider's sick pay plan grants employees the right to demand cash payment for unused sick leave at the end of each year, the pertinent accruals are includable, without funding, in the cost reporting period when earned.

8.26 Taxes and Fees

Taxes, including employee payroll taxes, sales taxes, and state imposed sales and use taxes, are allowable variable costs. The Michigan Single Business Tax is an allowable variable support cost.

8.26.A. General Taxes

Real and personal property taxes are allowable plant costs.

8.26.B. Quality Assurance Assessment Tax

A nursing facility's Quality Assurance Assessment Tax is an allowable cost and must be reported in the nursing facility Medicaid annual cost report. The tax must be reported on the provider's cost report as assessed and accounted for on the accrual basis. However, the cost is adjusted through the cost reporting process to be segregated from future cost bases.

8.26.C. Fees and Assessments

Costs incurred for late payments, or for violation of federal, state, or local laws are not allowable.

8.27 Therapy and Pathology Services

A nursing facility provider must establish accounting procedures to reflect individual cost centers for reimbursable ancillary services, including physical therapy, occupational therapy, speech pathology and other services not classified as routing nursing care. Whether the therapist/pathologist is salaried, under contract, or an independent provider, a nursing facility provider must record Medicaid program payments as income and all expenditures for therapist/pathologist supportive personnel, equipment and its maintenance, supplies, and other costs directly attributable to rendering services in these cost centers.

The service is considered ancillary if the complexity of the service prescribed for the resident is such that it can be performed safely and/or effectively only under the general supervision of skilled rehabilitation personnel. Ancillary therapy services are evidenced by the presence of the following conditions:

- A written physician order.
- The skills of a qualified technical or professional health personnel such as physical therapists, occupational therapists, speech pathologists or audiologists are required.
- Services are provided directly by, or under the general supervision of, the skilled personnel to assure the safety of the patient and to achieve medically desired results. General supervision requires that initial direction and periodic inspection of the actual activity is necessary.
- Services are rendered as part of an active treatment for a specific condition that has resulted in a loss or restriction of mobility or function.

Therapy services considered routine nursing care are services rendered under circumstances where the general supervision of exercises, which have been taught to the patient, can be performed repetitiously without skilled rehabilitation personnel. This includes maintenance programs where the performances of repetitive exercises, which may be required to maintain functions, do not necessitate a need for the involvement and services of skilled rehabilitation personnel. Routine nursing care may include repetitive exercises to improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

Depreciation for equipment and facility space assigned to these services must be included as an expense in the ancillary cost centers and computed in accordance with Medicaid guidelines for allowable depreciation. A uniform charge structure must be applied to the entire facility population receiving the services.

8.28 Personal Comfort Items

The costs of services and items that do not contribute primarily to the resident's treatment of an illness or the resident's ability to function are not allowable. Direct costs, and the appropriate share of indirect costs, relating to such items as telephones, televisions, radios that are located in the patient's accommodations and furnished solely for the personal comfort of the resident are not allowable. The cost of television and radio services furnished to residents generally are allowable if furnished in common use areas of the facility such as day rooms, recreation rooms or similar purpose area of the facility for the common benefit of facility residents. The cost of nurse-patient communications system that has no capability other than nurse and patient communication is allowable.

The costs of systems, including nurse-patient communications, television and telephone services, and similar items, may have the capability of providing residents with outside entertainment and providing nurse-patient communications. Only the cost of the component for nurse-patient communication is allowable routine nursing care. Direct distinction of cost related to the nurse-patient communication must be made for proper cost reporting, or an appropriate allocation must be established for Medicaid approval for the purpose of identifying the patient related and personal comfort related cost portions of combined systems.

SECTION 9 - COST CLASSIFICATIONS AND COST FINDING

Medicaid-enrolled providers must develop and adopt a uniform Chart of Accounts that meet the minimum requirements established by Medicaid for classifying and reporting costs incurred in providing care to nursing facility residents. A nursing facility's accounting system will normally include more detailed accounts for recording facility costs. However, for cost reporting purposes, the detailed accounts are compiled into aggregate cost classification centers in accordance with program policies.

The following cost descriptions are guidelines to provide consistency in nursing facility provider cost reporting. Reimbursement classifications are identified for individual cost elements in Attachment B of this chapter. More detailed discussions of cost categories are in the Allowable and Non-Allowable Costs section of this chapter.

9.1 NURSING FACILITY BED DAYS AND RESIDENT OCCUPANCY

A provider must report nursing facility bed days and resident occupancy statistics in the annual cost report. Policy related to facility census is presented in the Definitions section of this chapter. Specific attention should be directed to the following definitions: available bed, available bed days, ban on admissions, census, census day, denial of payment for new admissions, hold a bed day, leave day – hospital, leave day – therapeutic, occupancy, occupancy rate, per resident day cost, resident, resident days/occupancy, therapeutic leave day.

The nursing facility's resident occupancy statistics and cost reporting requirements will be significantly affected in cases where the provider requests, and is granted, approval for designating non-available beds as outlined in the Non-Available Beds subsection of this chapter.

9.2 VARIABLE COSTS – BASE AND SUPPORT

Variable costs include the total allowable base and support costs in a facility's routine nursing service units. A provider must allocate variable costs (support or base) depending on the activity for which the cost was incurred. The provider must also report direct costs for ancillary service costs and other non-reimbursable service costs. The direct costs incurred or attributed to these activities will not specifically be identified as base or support costs, however the cost report cost finding process will allocate general services cost activities as base or support cost depending on the activity for which the cost was incurred.

9.2.A. BASE COSTS

Base costs cover activities associated with direct patient care. Major activities under these categories are payroll and payroll-related costs for departments of nursing, nursing administration, dietary, laundry, diversional therapy and social services, food, linen (excluding mattress and mattress support unit), workers compensation, utility costs, consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments.

9.2.B. Support Costs

Support costs cover allowable activities not associated with direct patient care. Major items under these categories are payroll and payroll-related costs for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration, administrative costs, all consultant costs not specifically identified as base, all equipment maintenance and repair costs, purchased services, and contract labor not specified as base costs. Contract services costs for these departments are also support costs.

9.2.C. Base/Support Costs – Payroll Related

Nursing facility expenses related to payroll taxes and employee health and welfare are classified as base/support costs. These costs include fringe benefits such as employer contributions to FICA, FUTA, MESC, employee life and health insurance, retirement, physicals and all other insurance provided to employees as fringe benefits. If a nursing facility's accounting records do not separately reflect the payroll taxes and employee health and welfare expenses for "base" and "support" personnel by cost center identification, the total amount of these costs must be reported in the appropriate 'base/support' cost category. Workers compensation is a base cost and not divided between base and support.

If the nursing facility's accounting system allows the allocation of costs to specific personnel or activities, the specified costs must be used on the cost report. If the nursing facility accounting system does not allow for this specificity, then a reclassification of costs must be made to the appropriate service areas. In these cases it will be necessary to reclassify such costs on the basis of salary and wage costs distribution.

9.2.D. Base/Support Costs – Contract Services for Direct Patient Care

A provider that purchases direct care services as an alternative to employing personnel may apportion the contract services costs between base and support cost by applying the industry-wide average base-to-variable cost ratio. The nursing facility must appropriately report these costs in the annual cost report. Medicaid reviews the industry-wide average base-to variable cost ratio annually and revises it if a difference of 2% or greater exists between the current calendar year cost report aggregate average industry data and the previously promulgated industry-wide base-to-variable cost ratio. If a revision is applicable, the revised cost ratio will be effective for subsequent year cost reporting.

9.3 Plant Costs

Plant costs include depreciation, interest expense (either working capital or capital indebtedness), real estate and personal property taxes, amortization costs associated with loan financing costs (discount points, letters of credit), and specific lease expenses.

Providers must follow Generally Accepted Accounting Principles (GAAP) in reporting repairs to capital assets. Repairs that should be capitalized under GAAP must not be an expense item on the cost report.

9.4 Capital Asset Expenditure

Medicaid limitations on capital expenditure costs are determined in accordance with Medicare Principles except as modified by Medicaid policy.

A nursing facility provider anticipating capital expenditures over the required amounts should contact the CON Health Facilities Evaluation Section to make application for a CON. (Refer to the Directory Appendix for contact information.)

If a CON is approved, the provider may be eligible for increased reimbursement, subject to Plant Cost Component limits. If a new capital expenditure required CON review and was denied, the provider's reimbursement rate must exclude the costs of the denied capital expenditure. The provider's cost report must identify capital expenditures approved and denied by CON.

The nursing facility must have written policies and procedures that establish dollar level thresholds beyond which an asset acquisition is considered a capital asset. Medicaid sets the thresholds at having an estimated useful life of at least two (2) years and a historical cost of at least $5,000. The nursing facility capital asset policy may have lower dollar level threshold than the Medicaid limit, but may not have a higher limit. The provider must follow its established policy for cost reporting when its capitalization policy sets lower thresholds than Medicaid.

Assets that are acquired as part of an integrated system must be considered as a single asset for capitalization purposes. Assets that have a stand-alone functional capability may be considered on a single item basis. Individual asset items that do not meet the dollar and useful life threshold are classified as minor equipment and will be reported as minor equipment expense in the cost report of the year of acquisition.

Repair and improvement costs related to previously acquired assets that result in extending the useful life or increased productivity of the asset must be classified as a capital expenditure. Asset related expenditures required to be capitalized by the Internal Revenue Service (IRS), or chosen to be capitalized for the IRS, must be capitalized for Medicaid cost reporting purposes.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger), for which any payment has previously been made by the Medicaid program, are not recognized as reasonable in the provision of health care services.

9.4.A. Capital Asset Cost Data for Class I Facilities

9.4.A.1 Capitalized Asset Acquisition Costs

Capitalized asset acquisition costs are used to determine the Current Asset Value for the Plant Cost Component in the Class I nursing facility reimbursement rate. The Medicare Principles of Reimbursement are used to determine the acquisition costs allowable to the original provider/owner of the asset. The SMA uses only the acquisition cost incurred by the original owner to determine the capital asset value cost data. Asset acquisition costs

are allowed for related party transactions in accordance with Medicare's interpretation for costs to related organizations.

The historical cost of capital assets is based on the original owner's audited historical acquisition cost. It is the responsibility of the current owner to provide the audited historical acquisition cost and purchase year of the original owner; otherwise, the assets are assumed obsolete for payment determination purposes, i.e., of no current asset value. The current provider must annually report the cost and the applicable year's depreciation for newly purchased assets and value changes to previously acquired assets. Cost reporting for asset acquisition costs related to a capital asset that is traded-in for a new replacement item must also report the value of the capital assets.

Capital costs related to assets that are no longer used in the facility operation and assets that are not necessary for resident care, e.g., excessive land not allowed under the Principles, are not allowable in the nursing facility capital asset value cost data.

To ensure that Medicaid does not pay for assets that are no longer being used to provide resident care, the original acquisition costs, or an estimate thereof, is removed from the current capital asset cost data. The costs of retirement or replacement of buildings, building improvements, building additions, fixed building equipment, land improvements, or movable equipment is removed from the capital asset cost data for the corresponding year of the original acquisition of that retired or replaced asset.

When the original value can be ascertained through such methods as component part depreciation records, the provider must remove the original costs of the retired or replaced assets from the year of the original acquisition, and report the new asset item cost for the year purchased.

Building components, building services equipment or other fixed equipment assets or land improvements may have historically been included within the asset price of the building to which they are attached, and as a result, are not separable for purposes of calculating depreciation or the capital asset cost data. However, in the determination of the Current Asset Value, an asset must exist in the nursing facility for it to have a value. Therefore, if a fixed asset has been retired or replaced and the asset cost cannot be determined from the provider's Medicaid/Medicare asset cost schedule, construction records, or tax records, the provider must determine and report the original asset cost based on the cost of a similar asset.

If a nursing facility provider is unable to report the original asset cost by either individual asset cost or component basis, the new asset will be assumed as a replacement of a similar asset for determining the necessary revisions to the capital asset cost data using the asset trade-in provisions.

When a capital asset is traded-in for a new replacement item, either the historical acquisition cost or a derived value of the item traded in is removed from the historical capital asset cost data. The purchase price of the new asset, prior to consideration of the value of any trade-in, is added into the capital asset cost data for the current year of purchase. If the original cost of the item is unknown, the provider must derive a value by backdating the purchase price amount for the new replacement asset. If the asset being replaced is of a different quality or type than the new asset, the amount to be

backdated may be based on the expected current cost of a similar asset of like quality and type. The derived value calculation is made by applying the annual Marshall Valuation Services Book of Comparative Cost Multipliers (exclusive of the annual obsolescence adjustment) to the value of the new asset item cost, then subtracting the derived value from the previous capital asset cost data historical cost for that original acquisition year. An electronic copy of the annual economic index compilation and reference to Marshall Valuation data, and the derived application process used for nursing facility cost reporting can be accessed on the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Long Term Care Provider Forms.

Capital assets that are leased or rented are treated as obsolete assets for rate determination purposes when the underlying historical acquisition cost to the original owner has not been disclosed, or when the underlying information cannot be verified through audit.

Capital assets recorded in the central office, home office, or related organization financial records, that are identifiable to a specific nursing facility, are included in that facility's capital asset cost data determination process. The asset values, interest, and property taxes identified with these assets must be charged directly to the nursing facility and will be reimbursed in accordance with the applicable policy.

Costs of capital assets associated with the operation of related organizations are not included in the capital asset cost data determination for a specific nursing facility. The plant and variable costs of such organizations are treated as purchased services. (Refer to the Variable Costs – Base and Support subsections for discussion regarding purchase and contract services.)

9.4.A.2 Exceptions to Asset Acquisition Cost Capitalization

Exceptions to the acquisition cost basis for assets may be allowed in the following situations:

- For the occasional purchase of used, movable equipment for ongoing nursing facility operations when the purchase is not related to a change in facility ownership. For the purchase of used replacement equipment, e.g., re-manufactured beds, a used lawn tractor, or used vehicles, the asset acquisition is treated as if new items were purchased. The allowable cost of acquisition is included in the year the asset is put into service by the current purchaser.
- For the nursing facility land value. The land value to be included in the Current Asset Value is based on the current owner's allowable acquisition cost determined in accordance with Medicare Principles, and not to exceed the amount reported to the Internal Revenue Service for federal tax purposes. The prior owner's historical land improvement related asset costs that are an integral part of the nursing facility land component, and are part of the new or current owner's land acquisition cost, must be excluded from the historical capital asset cost data. The current facility ownership capital asset cost data cannot include both the land purchase price and the original owner's land improvement cost data. When the current owner's land acquisition value is used as the

basis for the land asset cost, the historical land improvement related asset costs of prior owners must be excluded from the historical capital asset cost data.

- When equipment is purchased as "used" equipment as part of a facility change of ownership, or only a change of ownership of the facility equipment has occurred, the prior owner's (seller) computation of value at the time of sale is continued to the new owner.

9.4.B. Capital Asset Categories (Fixed Assets)

Capital asset classifications and asset useful life for depreciation purposes are determined in accordance with the American Hospital Association (AHA) guidelines in effect at the time of the asset acquisition.

General descriptions of the asset cost categories for cost reporting are:

Land – includes the land owned and used in the provider operations and includes off-site sewer and water lines, public utility costs necessary to service the land, government assessments for street paving and sewers, cost of permanent roadways and grading of a non-depreciable nature, cost of curbs and sidewalks where the replacement is not the responsibility of the nursing facility, and other land expenditure of a non-depreciable nature.

Land Improvement – improvements of a depreciable nature including paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the nursing facility.

Building – includes the basic building structure, shell or frame, and additions thereto, building components, exterior walls, interior framing, walls, floors and ceiling, architectural, consulting, and interest expense associated with new construction or acquisition.

Building Improvement – includes building equipment attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of fixed equipment are: (a) attachment or installed to the building structure, and (b) fairly long life but may be less than the building.

Leasehold Improvement – includes betterments and additions made by the lessee to the leased property, whereby the improvements become the property of the lessor after expiration of the lease. These items generally meet the requirements of building improvement assets.

Department Equipment – includes assets generally assigned to a specific department within the nursing facility with relatively fixed location but capable of being moved; as distinguished from building equipment. (Refer to Building Improvement)

Furniture and Fixtures – includes assets similar in characteristic to department equipment, however normally with no fixed location, or used by various departments within the facility.

Transportation Equipment – includes vehicles used in conducting of nursing facility operations relative to resident transportation, plant operations and maintenance, or general means of transport.

Capital - asset costs incurred by a landlord that is leasing facility assets to a provider must be disclosed and reported in the provider's annual cost report. Capital asset cost reporting and allowable cost policies are applicable to the reporting of the leased assets in the same manner as if the assets were owned by the provider**.**

9.4.C. Depreciation

Class I and Class II nursing facilities are under the tenure plant cost reimbursement methodology and potential reimbursement is not based on depreciation expense for the nursing facility capital assets. The costs of services provided from home office or related party transactions, other than for capital assets related to the nursing facility physical plant, may include depreciation expense for asset costs applicable to the operations of the home office or related party business. Allowable depreciation costs for the home office or related party will be determined in accordance with Medicare Principles. These costs will be included in the home office or related party administrative services space costs and must be reported in accordance with Medicaid policy identified in the Related or Chain Organization Cost Allocations subsection of this chapter. Class III and Class IV nursing facilities reimbursed under the depreciation plant cost reimbursement methodology will have depreciation cost determined in accordance with allowable cost principles defined in this policy. The allowance for depreciation is determined in accordance with Medicare Principles except that only the straight-line method of depreciation may be used. The historical asset cost basis and the depreciation basis for nursing facility sales is subject to the limitation on the valuation of assets mandated by the Medicare Principles.

In addition to the depreciation standards in the Medicare Principles, Medicaid also requires adherence to the following standards:

- Consistent use of either component or composite asset depreciation schedules. Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined. Composite depreciation must be used in the case of a newly purchased, existing facility.
- All abandonment losses are considered as a depreciation expense item.

9.4.D. Disposal of Depreciable Assets

9.4.D.1 Class I Nursing Facilities

Class I nursing facilities will account for asset acquisition and disposal in accordance with the Capital Asset Cost Data for Class I Facilities subsection of this chapter.

A Class I nursing facility purchased on or after March 31, 1985 is not subject to depreciation adjustment. In the event of a sale, the assets of Class I Providers whose ownership began prior to March 31, 1985, amounts included in the Medicaid per diem

rate as an explicit depreciation expense item are subject to recapture in the event of a gain on the disposal of assets. The selling Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal year cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment subsection of this chapter for additional information.

9.4.D.2 Class III Nursing Facilities

Class III providers whose Medicaid rate includes depreciation expense must adhere to the Medicare Principles of Reimbursement to account for the disposal of depreciable assets. If the disposal of depreciable assets in the reporting year results in a gain or aggregate loss below $5,000, the adjustment will be made in the nursing facility provider's current year cost reporting allowable cost. The allowable gain is limited to the amount of depreciation previously included in the provider's allowable costs for the disposed assets.

In the event of a sale of the entire nursing facility and the termination of Provider participation in the Medicaid program, the terminating Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal period cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment section of this chapter for additional information.

9.5 Loans/Borrowings Balance Reporting

Necessary and proper interest on current and capital debt is a Medicaid allowable cost. All interest expense, whether on current or long term debt, is classified as a plant cost. Determination of allowable interest expense will be in accordance with Medicare allowable cost principles. However, there are reimbursement limits for determining the Plant Cost Component specific to Medicaid, which are addressed in Rate Determination section of this Chapter.

Medicaid requires nursing facilities to report the loans and borrowings balance in the annual cost report. The cost report instructions identify the schedules that must be used to report borrowing principle balances. The nursing facility must report the beginning balance and monthly end balance of outstanding allowable loans and borrowings for the time period corresponding to the cost report year. The loans and borrowings in the borrowing balance report must only include the outstanding loans or other liability obligations for which the nursing facility is claiming interest expense related to that borrowing principle. If the nursing facility is filing a cost report claim for interest expense as an allowable cost, the nursing facility must document the corresponding borrowing obligation related to the interest expense. The outstanding borrowing balance is defined as the allowable borrowing principle amount on which the interest rate, normally expressed as an "interest rate percentage", is applied for the purpose of calculating the interest expense applicable to the specific cost report time period.

Loans from related parties or unallowable borrowings must be excluded from the cost report borrowing balance schedule. The interest incurred on excluded borrowings must be removed from incurred interest costs in a like manner. Interest income or investment income which is required to be offset to interest expense in the cost report period must not to be considered a reduction in the outstanding borrowing balance principle.

Mortgage principle balances or similar finance arrangements for the purpose of nursing facility or business acquisition must be separately identified from other loan balances in the cost report borrowing balance schedule. Examples of other loan balances include working capital and miscellaneous asset acquisition purpose loans. In the event of refinancing and co-mingling of separate loan balances into a single finance arrangement, the nursing facility must identify the appropriate portions of the combined financed amount used for different purposes, and maintain the separation for cost reporting. Likewise, multiple loans for the same purpose must be combined for the appropriate category for cost reporting.

Borrowing principle obligations incurred by a home office must be reported on the individual nursing facility cost report borrowing balance worksheet only for loans directly associated with financing the individual nursing facility asset purchases or facility acquisition costs. The interest expense applicable to such loans must also be identified, directly charged to the individual nursing facility, and reported as interest expense for the nursing facility. Working capital and other loans incurred directly under the home office operation and not related to nursing facility acquisition are considered general administrative costs and are included, to the extent determined necessary and reasonable, in the home office cost allocation to the individual nursing facilities and other business operations of the corporate chain.

Allowable outstanding loan balances of landlord entities that are leasing nursing home facility assets to a provider must be disclosed and reported in the provider's annual cost report. Borrowings balance cost reporting and allowable cost policies are applicable to the reporting of the underlying cost of the landlord entity in the same manner had the borrowings been recorded on the financial records of the provider.

9.6 Cost Finding

Cost finding is the process of recasting the data from the accounts kept by a provider to determine the cost of services rendered, allocating direct costs, and prorating indirect costs in accordance with Medicare Principles of Reimbursement, except where modified by Medicaid policy. Medicaid determines reimbursement rates for nursing facility providers based on specific categories of cost, as addressed in other sections of this chapter.

9.6.A. Cost Allocation Basis

The Medicaid cost reporting process establishes the cost finding process. Indirect and non-revenue producing cost centers are allocated using a statistical basis that reflects an equitable measurement of the services provided to, or benefits derived by, a revenue producing or non-reimbursable activity. The nursing facility must develop and maintain adequate statistical data to corroborate the basis of the cost allocation. Adequacy requires that the data be accurate and in sufficient detail to accomplish the purpose for which it is intended. When completing the allocation of the general service cost centers, the nursing facility provider should first allocate those cost centers that render the most services to, and receive the least services from, other cost centers.

9.6.A.1. Facility Square Footage and Space Reporting

A facility space cost allocation is based on square footage identified with specific service areas or activities occupying and using that space. Square footage is an allocation base that may be applicable for multiple indirect cost center activities. However, for cost centers where the basis is the same (e.g., square feet), the total statistical basis over

which the costs are to be allocated will differ because of the prior elimination of cost centers that have been allocated.

A consistent and uniform process must be used by the nursing facility for compiling and charging the square footage to each service activity that is primarily benefiting from or using that space. Facility space that is used for multiple activities must be documented and connected to each applicable activity based upon current data that reflects actual use and is available for audit verification. Hallway space located within a specific department or service area is considered usable space for that department. Areas of the facility for general use, such as connecting hallways, reception areas, lobby, elevator, used or benefiting all service activities are considered common space. Identifying and counting common space must be consistent for all service areas of the facility. For example, common space in one service department cannot be excluded from space allocated to that service activity, while similar common space located in other services departments is included in the space allocation of other services activities. The allocation basis must apply either the gross method, where all common area is included and charged to the specific services activity, or the net method, where common space located within the identified service area is not charged to the service activity. The nursing facility's handling of common space area in the cost report allocation must result in equitable distribution of costs associated with the common space to appropriate activities. A change in the process or methodology that the nursing facility uses for allocating space is a change in allocation basis, so appropriate notice and a request must be made to the SMA.

9.6.A.2. ANCILLARY/THERAPY SERVICES SPACE REPORTING

Facility space used for ancillary services delivery must be identified and charged to the appropriate ancillary services cost center. For example, space used for skilled rehabilitation services provided based on a physician's order must be allocated to the appropriate ancillary cost center.

Accounting procedures must be established and implemented to reflect individual cost centers for reimbursable therapy and pathology services. Irrespective of the therapist or pathologist's status as an employee, contractor or independent provider, the nursing facility must record all payments as income and all expenditures for supportive personnel, equipment and its maintenance, supplies and other costs directly attributable to reimbursable expenses in these cost centers.

9.6.A.3. ANCILLARY/THERAPY SERVICES ADMINISTRATIVE OVERHEAD

Medicaid requires that administrative overhead associated with ancillary services be allocated to the ancillary services cost center. The required basis for distribution of administrative costs to the benefiting activities of the nursing facility is accumulated costs. The accumulated costs base generally includes all services activities of the nursing facility.

In specific situations, the nursing facility may request exclusion of certain ancillary service groups from the administrative cost overhead allocation in the Medicaid cost report. The determination applies only to those service items where the billing to the

third party only allows for the recovery of the direct cost of the service. The provider must demonstrate considerable inequity of the overhead cost allocation to these service activities that have been identified as excluded groups under the Medicare regulations and that it is not incurring additional costs beyond the activity for arranging for the services. The incidental costs for inclusion of the ancillary service bill preparation must be as follows:

- The facility representatives arrange for the services to be performed by an agency or entity that is not part of the nursing facility operation.
- The nursing facility is not directly involved in providing the ancillary service.
- The nursing facility does not incur any costs for supplies and equipment necessary to perform the service.
- The ancillary service is being recorded through the accounting records and billing system of the nursing facility for the consolidated billing of the services provided to the nursing facility resident.
- The nursing facility does not have physical space dedicated for the purpose of delivery or rendering of the ancillary service. Dedicated space is considered space that is used predominantly for the purpose of the ancillary service delivery.
- The nursing facility is not charging a mark-up related to the billing of the service.

If the nursing facility is allowed to bill for or recover revenue in excess of the direct cost of the services, the statistical and fiscal worksheet of the cost report and may be adjusted to reflect the revenue received. The amount of revenue exceeding the direct cost will be considered the overhead amount that must be reflected as an adjustment to the "miscellaneous expense" in the Administrative and General cost center, in addition to the direct cost adjustment to exclude the ancillary service cost from the cost allocation step-down. The nursing facility must demonstrate that the excess revenue is a fair representation of the overhead cost or activity associated with providing the service. If this requirement is not met, the ancillary services activity must be included in the administrative cost allocation basis for the apportionment of overhead to the activity.

9.6.B. Change in Cost Allocation Basis

A provider who wishes to change the allocation basis for a particular cost center, or the order in which the cost centers are allocated, must submit a written request to the RARSS. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The request must include reasonable justification and supporting documentation that the new basis is more accurate and appropriate for allocation of the cost activity for Medicaid reimbursement determination. The request must be made prior to the beginning of the cost-reporting period in which the change is to apply. The effective date of the change will be the beginning of the cost-reporting period for which the request has been made. Failure to submit a timely written request will result in an audit adjustment. The nursing facility provider must maintain both prior and proposed statistics base data until the change is approved.

Medicaid may reject a submitted cost report if a request to change the allocation basis has not been submitted and approved by RARSS. If the previous allocation basis

methodology has not been maintained for the current year, Medicaid may accept previous year's statistics for the current year cost reporting.

9.6.C. Related or Chain Organization Cost Allocations

The Medicare Principles of Reimbursement define a related organization as an organization linked to a nursing facility provider by common ownership or control, including a chain organization. An immediate family relationship establishes an irrefutable presumption of relatedness.

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization. To the extent that the home office furnishes services related to patient care to the nursing facility, the reasonable costs of the services are included in the nursing facility's cost report. Medicaid policy for related organization costs is determined in accordance with provisions in the federal Provider Reimbursement Manual for related organization costs. Exceptions to the application of federal provisions are addressed in the Cost Classification and Cost Finding and Allowable and Non-Allowable Costs sections of this chapter.

Home office costs apportioned to individual nursing facilities through the Home Office Cost Statement are classified as support costs. Cost report requirements for home office are addressed in the Cost Reporting section of this chapter.

Costs incurred by a nursing facility for services furnished by the related organization are allowable costs to the nursing facility at the level of cost to the related organization for the service provision. The cost allocated to the nursing facility cannot exceed the price of comparable services, facilities, or supplies that could be purchased in competitive market conditions. The principles of reimbursement applied for the determination of allowable cost to the nursing facility are also applicable in the determination of the allowable cost of the related organization. If a cost would be unallowable to the nursing facility, it would be unallowable to the related organization.

The operating costs of a related ownership organization are allocated to an individual nursing facility as a "purchased service" and must be identified within the appropriate cost center for Medicaid cost reporting. The type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility. Refer to the Cost Classification and Cost Finding section of this chapter for additional information.

If the home office accounting period differs from the cost reporting period of the nursing facility, the allowable home office costs in the facility cost report must only include the costs allocated to the facility for the time period in which the completed home office cost statement coincides with the facility's cost report period. There may be a portion of the year where home office costs have not yet been determined or finalized. The facility must submit to RARRS a disclosure letter with it's cost report data stating that the cost report includes partial year home office costs. After the home office reporting period is

completed, the nursing facility must amend it's cost report submitted to RARRS to include complete home office cost data. The cost report filed originally will be used for Program reimbursement actions until an amended cost report is filed. An accepted, amended cost report will be used for reimbursement determination actions for the same time period as the initial cost report. The nursing facility amended cost report must be submitted to RARSS within 3 months after the end of the home office or related party cost report year. Amended cost reports submitted after the 3 months filing requirement will be effective only on a prospective basis for the routine nursing care per diem rate determination. The Medicaid audit of the home office cost statement and related allocation to the nursing facility will be made in accordance with the final cost report filing data.

Example: The home office has an accounting year ending August 31; Nursing Facility A has a cost report year ending December 31; Nursing Facility B has a cost report year ending March 31.

Year 1

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2003 – 8/31/2004 $204,000		
Allocation to chain provider facilities	$120,000	$84,000
Applicable to facility cost report year	12/31/2003 - 3/31/2004	
4 months 9/1/2003 – 12/31/2003	$40,000 (4/12)	
7 months 9/1/2003 – 3/31/2004		$49,000 (7/12)
Applicable to facility cost report year	12/31/2004 - 3/31/2005	
8 months 1/1/2004 – 8/31/2004	$80,000 - (8/12)	
5 months 4/1/2004 – 8/31/2004		$35,000 (5/12)

Year 2

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2004 – 8/31/2005 $228,000		
Allocation to chain provider facilities	$132,000	$96,000
Applicable to facility cost report year	12/31/2004 - 3/31/2005	
4 months 9/1/2004 – 12/31/2004	$44,000 (4/12)	
7 months 9/1/2004 – 3/31/2005		$56,000 (7/12)
Applicable to facility cost report year	12/31/2005 - 3/31/2006	
8 months 1/1/2005 – 8/31/2005	$88,000 (8/12)	
5 months 4/1/2005 – 8/31/2005		$40,000 (5/12)

Year 3

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2005 – 8/31/2006 $216,000		
Allocation to chain provider facilities	$126,000	$90,000
Applicable to facility cost report year	12/31/2005 - 3/31/2006	
4 months 9/1/2005 – 12/31/2005	$42,000 (4/12)	
7 months 9/1/2005 – 3/31/2006		$52,500 (7/12)
Applicable to facility cost report year	12/31/2006 - 3/31/2007	
8 months 1/1/2006 – 8/31/2006	$84,000 (8/12)	
5 months 4/1/2006 – 8/31/2006		$37,500 (5/12)

Individual Nursing Facility Cost Reporting	**Facility A**	**Facility B**
Amount reported in facility cost report initially filed for:	FYE 12/31/2004	FYE 3/31/2005
Home office cost year 8/31/2004	$80,000 (8 months)	$35,000 (5 months)
Amount reported in facility cost report amended for:	FYE 12/31/2004	FYE 3/31/2005
Home office cost year 8/31/2004	$80,000 (8 months)	$35,000 (5 months)
Home office cost year 8/31/2005	$44,000 (4 months)	$56,000 (7 months)
Total home office costs in cost report	$124,000	$91,000
Amount reported in facility cost report initially filed for:	FYE 12/31/2005	FYE 3/31/2006
Home office cost year 8/31/2005	$88,000 (8 months)	$40,000 (5 months)
Amount reported in facility cost report amended for:	FYE 12/31/2005	FYE 3/31/2006
Home office cost year 8/31/2005	$88,000 (8 months)	$40,000 (5 months)
Home office cost year 8/31/2006	$42,000 (4 months)	$52,500 (7 months)
Total home office costs in cost report	$130,000	$92,500
Amount reported in facility cost report initially filed for:	FYE 12/31/2006	FYE 3/31/2007
Home office cost year 8/31/2006	$84,000 (8 months)	$37,500 (5 months)

Individual nursing facility cost reports for 12/31/2006 and 3/31/2007 must be amended following completion of the home office cost reporting year 8/31/2007 to include the portion of that year costs in the nursing facility cost report.

9.7 Distinct Part Unit Reporting

For reimbursement purposes, the Nursing Facility is defined as the unit that is certified for participation in the Medicaid program, whether that unit comprises all of, or a distinct part of, a larger institution.

Certification regulations require that a distinct part be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The provider must demonstrate to Medicaid that the system used for recording the hours of nursing services can be audited and equitably allocates the nursing services costs between the distinct part and other parts of the facility. The nursing services costs are only the gross salaries and wages of nursing and related personnel, such as registered nurses, LPNs, and CNAs. Costs applicable to general services areas of the institution must be allocated in accordance with the Cost Finding section of this chapter.

Nursing services costs allocated to that distinct part of the facility must relate only to services provided to those residents. While a provider may choose the record keeping method used to allocate these costs, the preferred system is time records identifying the time spent providing nursing care in the Medicaid distinct part and in other parts of the institution. Providers using the preferred method must obtain approval from the RARSS prior to changing its cost allocation method. The request must identify the reason for the change and must demonstrate that the proposed method is representative of actual

nursing staffing within the facility and results in an equitable and accurate allocation of nursing services costs.

A nursing services cost allocation using an average cost per patient day may be used in the following situations:

- In the case of inadequate payroll record keeping.
- Facility failure to maintain assignment schedules or staffing reports.
- With prior permission from RARSS.

An institution may have more than one Medicaid distinct unit in specific cases where Medicaid has certified beds as special use for specialized nursing care. The specialized nursing care beds must be physically distinguishable, within a designated area, and identified as a separate nursing bed class for Medicaid reimbursement. Requirements for reporting nursing services costs also apply to nursing services for residents in specialized nursing care beds. The nursing facility must have prior approval from Medicaid for participation in a program for specialized nursing care.

9.8 Day Care Services for Nursing Facility Employee Dependents

Employee fringe benefits do not include items that are furnished to the employee for the convenience of the provider. A nursing facility operating a day care center for the children of its employees is classified as such an activity and must not be included in facility costs as an employee fringe benefit. The costs may be allowable only to the extent that the amount is reasonable and related to patient care as defined in the CMS Provider Reimbursement Manual. "Reasonableness" means that the services are provided in accordance with regulations established for the provisions of such services and must take into account both direct and indirect costs of the services. "Related to patient care" means that the costs are necessary and appropriate for maintaining the operation of the nursing facility. In order for the day care costs to be allowable, they must also meet the following requirements:

- The day care center operations must be provided in accordance with, and satisfy applicable regulatory requirements, governing the operations of such activities.
- If applicable, the nursing facility must provide to employees using day care center services, a report of the dollar amount of those services in accordance with applicable Internal Revenue Service requirements.
- Total cost must not exceed what a prudent and cost conscious buyer pays for like services. If costs are determined to exceed such level and the nursing facility cannot provide clear evidence that the higher costs were unavoidable, the excess costs are not allowable.

The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

9.9 Nurse Aide Training and Competency Evaluation Program (NATCEP) and Competency Evaluation Program (CEP)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires that any nurse aide employed in a nursing facility complete a competency evaluation program. Medicaid will reimburse a Medicaid certified nursing facility for the Medicaid share of allowable costs directly related to meeting the nurse aide

training and competency evaluation requirements. Reimbursement includes only costs incurred with a NATCEP or CEP approved by the State Survey Agency (SSA). Medicaid reimbursement applies only to Certified Nurse Assistants (CNA) working in a Medicaid certified nursing facility and are not available to CNAs in other residential or patient care settings.

A nurse aide who is employed by a nursing facility or who has received an offer of employment from a nursing facility on the date on which the nurse aide begins a NATCEP may not be charged for any portion of the cost of the program. The employing nursing facility is responsible for reimbursement to the CNS for the costs of training and competency evaluation. The nursing facility must reimburse newly employed CNAs who have personally paid for NATCEP or CEP costs prior to employment in the facility, in accordance with criteria identified in the Nurse Aide Reimbursement section of this Chapter. Medicaid in turn reimburses the nursing facility.

9.9.A. Nurse Aide Competency Evaluation Program and Nurse Aide Registry

Nurse aide candidates must pass both a clinical skills test and a knowledge test in order to become certified. Fees for the individual nurse aide to take the tests, and retake each test- up to three times - are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this chapter.

When a nurse aide has successfully passed the CEP, their name is placed on the Michigan Nurse Aide Registry. Fees relating to initial registration and bi-annual registry renewal are allowable costs for the nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this chapter.

Information about training requirements, competency evaluation program and registry data is available on the MDCH website at www.michigan.gov/mdch, click on Health Systems & Licensing, Licensing for Health Care Professionals, Nurse Aide.

9.9.B. Nursing Facility Reimbursement

Reimbursement to the nursing facility for NATCEP related costs is made by an add-on to the routine per diem rate. The total NATCEP add-on amount will be adjusted through the annual cost report settlement process. The Medicaid share of the costs is computed based on the ratio of Medicaid resident days to total resident days for all long term care licensed beds in the facility for the cost report period. Refer to the Cost Report Reimbursement Settlement section and Rate Determination section of this chapter for additional information.

The NATCEP cost center on the Medicaid cost report must be used to report the following:

- Costs of conducting a nursing facility based NATCEP.
- Costs of having employees participate in an approved NATCEP outside the nursing facility.
- Costs of employee competency testing by a regional testing facility.

The costs and staffing levels relating to and charged to the NATCEP cost center must not be included in the nursing facility determination of routine nursing care costs.

The determination of allowable NATCEP costs is made in accordance with provisions in the federal Principles of Reimbursement established for the Medicare Program, and cost limitations in Medicaid policy. Training and evaluation program costs claimed for services and supplies furnished to or purchased by the facility from related organizations must adhere to related party allowable cost principles. The cost of such transactions must not exceed the cost of like items or services in an arms-length transaction with a non-related organization, or the actual cost to the related organization, whichever is lower.

The following are not NATCEP costs and must be classified as routine nursing care costs on the cost report:

- Administrative overhead in a facility-based training program.
- Space costs in a facility-based training program.
- Uniform allowance costs.
- Required in-service training.

NATCEP and CEP allowable cost must only include the costs of activities or items that are directly related to providing approved training and the competency evaluation process. The following table contains eligible training and evaluation activities.

Training staff	Salaries and wages, employee benefits and payroll taxes for conducting training and evaluation activities, including supervised practical training, and direct time devoted to development and preparation for conducting the NATCEP. Payroll costs allowed for NATCEP do not include the cost of time that the training staff devote to routine in-service training activities, general nursing administration or direct patient care, except for supervised practical training. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Consultants	Costs incurred for non-facility staff to assist in developing and conducting the facility's NATCEP.
Student Staff	Salaries and wages, employee benefits and payroll taxes incurred for the time the student is enrolled in the approved training program, i.e., classroom and required supervised practical training. A reasonable time allowance for student employees traveling to and from the off-site training location or competency evaluation, in accordance with a nursing facility's established and documented travel policy, is allowable as NATCEP cost. Payroll cost allowed for NATCEP do not include the cost of staff time for patient care activities that the nurse aide is performing during the time period in which he is completing the training program. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.

Training Program Supplies	Costs of supplies and materials used in conducting an approved NATCEP.
Training Program Transportation	Travel or transportation cost incurred by facility staff in conducting the NATCEP activity, and for transportation or travel reimbursement to student staff for off-site NATCEP or CEP attendance. Refer to the Facility Vehicle and Transportation, Allowable and Non-Allowable Cost section of this chapter for mileage allowance provisions. Use of a facility owned vehicle for staff transportation for training is not charged to NATCEP. Facility vehicle operation cost must be classified as administrative overhead and is considered in the routine per diem rate.
Outside Contracted NATCEP Paid Directly by the Facility	Cost to obtain approved nurse aide training of facility employees by an outside entity approved NATCEP. The nursing facility is responsible to ensure that the contractor is an approved NATCEP.
Outside Contracted NATCEP Costs Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for an approved NATCEP participation and completion prior to being employed in the facility. Refer to Nurse Aide Reimbursement.
Competency Evaluation Fees Paid Directly by the Facility	Fees paid by the nursing facility to a State-approved competency evaluator. This includes testing and retesting fees, rescheduling fees, and nurse aide registry.
Competency Evaluation Fees Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for State-approved competency evaluation and registration fee prior to being employed in the facility. Refer to Nurse Aide Reimbursement.
Miscellaneous Costs	Allowable costs that are not specifically identified in another category include, but are not limited to the following items: ▪ Rental costs for space located out of the facility are allowable only if the space is used solely for the training and competency evaluation program. Space costs not meeting this requirement are reimbursable with the Plant Cost Component of the routine per diem. ▪ Reasonable rental expense for training equipment necessary for conducting an approved training program. Nurse aide bi-annual Registry Document renewal fees for current employees.

Equipment Purchased	Equipment purchased and used specifically for the nursing facility based NATCEP are reported as NATCEP cost center costs for Medicaid cost reporting and reimbursement purposes. NATCEP equipment costing less than $5,000 may be expensed in the year of acquisition and reported in the NATCEP cost center. Equipment acquired as part of integrated system costing greater than $5,000, must be amortized at an annual rate of 15% for each cost reporting year the equipment is used in the NATCEP, up to a maximum of seven years. Instructions for NATCEP equipment reporting are included in the annual cost reporting instructions.

9.9.C. Nurse Aide Reimbursement

A nursing facility must reimburse a newly hired CNA if the CNA paid for nurse aide training, competency evaluation and registry, and completed the approved training program within 12 months prior to employment in that facility. The nursing facility is not required to reimburse the CNA in cases where the expenses were paid by an employment or education training program, or were reimbursed by the CNA's previous employer. The nurse aide should not be reimbursed for more than 100 percent of the NATCEP or CEP costs they paid.

The CNA must request reimbursement by submitting to the nursing facility the Nurse Aide Training and Competency Evaluation Program, CNA Reimbursement Form, available in the Forms Appendix of the Medicaid Provider Manual.

NATCEP costs that are eligible for reimbursement to the individual nurse aide include:

- Training program cost including fees for textbooks and required course material up to a maximum of $650. Medicaid will update the maximum allowable reimbursement limit effective October 1, 2006, and each bi-annual period thereafter, based on the Global Insight's Skilled Nursing Facility Market Basket without Capital Index corresponding to that update period.
- Competency Evaluation Program testing fees, including retesting fees ; CEP testing required due to the nurse aide registry document expiration; and rescheduling fees.
- Registry or Registry Renewal Document fees that the CNA personally paid within 24 months prior to being employed in the nursing facility.

The nursing facility is responsible to ensure that a newly hired CNA who requests reimbursement of training and testing expenses has not already received payment for these costs. An aide who paid for any of these eligible costs and received payment of a portion of the expenses from prior facility employment is eligible for only the remaining balance from the new employer.

For cost reporting and audit purposes, the nursing facility must maintain, a copy of the Nurse Aide Training and Competency Evaluation Program CNA Reimbursement Form signed by the employee and documentation reflecting payments made by and reimbursed to the employee. This documentation must include a copy of a receipt for cash payment, a copy of a cancelled check, or a credit card receipt showing the amount

paid by the nurse aide and the date of payment, as well as copies of the nursing facility's cancelled checks disclosing reimbursement to the employee.

The nursing facility has the option to reimburse the individual via a one-time payment, or payment installments. The reimbursement to the individual, regardless of full-time or part-time employee status, must be fully paid within six-months of the individual's date of employment in the facility. If the nursing facility fails to reimburse a CNA employed in the facility within this timeframe, the unpaid balance will not be an allowable NATCEP or routine nursing care cost. This determination does not relieve the nursing facility of its obligation to reimburse the nurse aide. Wages may not be reduced to offset the facility obligation to pay the nurse aide for training, competency evaluation, and registry costs.

The nursing facility is not obligated to pay the remaining balance of nurse aide training costs at the time an employee who has worked less than six months leaves the facility employment. The CNA has the opportunity to recoup the non-reimbursed costs through subsequent employment at other nursing facilities. The facility should properly record payments so that the unpaid amount is not carried as a payment obligation.

9.9.D. Nursing Facility Lockout and Loss of NATCEP Approval

A provider with a facility-based training CNA program is not eligible for Medicaid reimbursement of training costs when it has been issued a final notice from CMS or the SSA of the withdrawal of NATCEP approval, or of a NAT prohibition (lockout). For Medicaid reimbursement purposes, the lockout effective time period coincides with the SSA time period notice to the nursing facility. The nursing facility must not claim Medicaid reimbursement for costs associated with any facility-based training class beginning after the withdrawal or lockout effective date identified in the final notice. Nurse aide students beginning training prior to the withdrawal effective date are allowed to complete training and the related costs to complete that training class are eligible for NATCEP reimbursement. Nurse aide training costs incurred for that facility based program subsequent to completion of that student class are not allowable NATCEP costs. This disallowed cost is also not allowable under routine nursing care cost.

Although the nursing facility experiencing approval withdrawal or lockout status cannot conduct its own training, the nursing facility must provide and reimburse for training and competency evaluation of its new nurse aide employees at approved sites. Such costs are eligible for Medicaid cost reporting and reimbursement in the annual cost report under the appropriate NATCEP cost categories. Nurse aide reimbursement for eligible training and competency evaluation personally paid expenses are allowable to be reported as NATCEP cost in the nursing facility annual cost report.

In the event that the nursing facility has been granted a waiver for a NAT program prohibition or lockout by the SSA, the nursing facility must comply with the provisions of the nursing facility waiver request, and the requirements set forth by the SSA in the waiver approval. The facility-based NATCEP operating under a waiver is subject to audit by Medicaid for compliance with these requirements. If the nursing facility fails to conduct the program in accordance with these requirements, the training program expenses are not allowable costs for NATCEP or routine nursing cost reimbursement by Medicaid.

9.10 Beauty and Barber Service Cost Center

Personal services for residents, such as simple barber and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets) that residents need are considered routine patient care. The costs of such services are reimbursed in the routine per diem rate when provided routinely without charge to the resident in the nursing facility.

If the nursing facility designates an area for providing non-routine personal hygiene services, such as professional manicures, or hair styling, costs must be separately reported and accounted for in the cost report. Direct and overhead costs related to these services must be separately accounted for in this special services cost center, and should not included in the cost of providing routine nursing care.

9.11 Special Dietary Cost Center

Medicaid provides for reimbursement outside the per diem rate to non-profit nursing facilities for the cost of meeting resident's special dietary needs for religious reasons. Nursing facilities requesting reimbursement must report these costs as a separate cost center in the Medicaid annual cost report. Direct costs may include food purchase, salary and wages for the extra staff time for preparation, supplies and kitchen utensils necessary for preparation and service. The costs applicable to plant operations costs related to the special dietary needs will be determined through the Medicaid cost finding process.

9.12 Hospital Leave Days

A separate accounting of costs incurred due to hospital leave days is not necessary. The provider must use the appropriate worksheet in the Medicaid cost report to reduce the nursing unit's variable base costs by a dollar amount equal to the "hospital leave day" revenues received for that nursing unit. The adjustment must include all payer sources for hospital leave day revenue. The account reference for this cost reduction adjustment appears in the instructions for completing the cost report and related worksheets.

Since hospital leave day revenue received is a reduction to cost, the hospital leave day is not included as a Medicaid cost report census day.

9.13 Non-Available Beds

In special circumstances, nursing facility beds may be designated "non-available for occupancy" for Medicaid cost reporting when the patient care rooms in which the beds are located are not used for resident care. Beds with a "non-available" designation remain licensed or certified; the designation is for Medicaid cost reporting and reimbursement determinations only. An approved non-available bed plan reduces the total number of beds used for calculating available bed days for the annual cost report period coinciding with the time period of the non-available bed plan. Non-available beds must be located in a discrete area and readily identified for statistical cost reporting. During the time period the area is designated non-available for patient care, Medicaid does not reimburse for variable and plant costs attributed to the area designated as having non-available beds.

9.13.A. Qualifying Criteria

A non-available bed plan must include all of the certified beds in a patient care room. The rooms must be a discrete area and primarily consist of a contiguous physical arrangement of rooms. Rooms may not be a random collection of individual rooms or beds located throughout the nursing facility.

Common physical space located adjacent to or within the designated rooms area will normally be included in the designated non-available bed area. Planned use of any common areas within the designated non-available bed area must be disclosed in the written notice to the RARSS.

Rooms with non-available beds may not be used for resident care service regardless of payer source or for any other purpose.

Resident rooms that are not used for resident care do not qualify for non-available bed designation. Although the rooms may be used for alternative services, the beds located within the room area must continue to be counted as available for resident care. Physical plant area used for alternative use must appropriately be charged to the applicable alternative services cost center if the services activity results in ancillary care services or other revenue services.

The written request must be submitted within 30 days of the date that the provider removes the beds from service.

9.13.B. Written Notice and Request for Plan Approval

The provider must submit a written request for a non-available bed plan to RARSS. The RARRS must receive the request within 30 days of the date that the beds are to be removed from resident care service. (Refer to the Directory Appendix for contact information.)

The written notice must:

- Indicate the date that the beds will be removed from resident care service and the expected duration of the non-available plan.
- Indicate the reason for the request.
- Include a floor plan of the facility that marks the beds to be designated as non-available.

The RARSS will review the request and provide a written response of approval, denial or a request for additional information. If approved, the RARSS will notify the SSA of the non-available bed designated rooms and effective time period.

9.13.C. Life of an Approved Plan

Beds must remain non-available for not less than the balance of the provider's fiscal cost reporting year in which the beds are deemed non-available plus the entire following fiscal year. An exception is when the non-available bed plan is effective on the first day of the

provider's fiscal year. The cost report year may quality as the entire time period of the non-available bed plan if the cost report period is not less than twelve months.

Non-available bed designations will be effective on the first day of the month. If the notice is not received within the required 30-day period, the plan will become effective on the first of the month in which RARSS received the notice.

The initial period of the non-available bed plan expires upon completion of the minimum required time period.

The nursing facility may request an extension for one year following this minimum time period. The agreement may be extended on the basis of the provider's fiscal year. A request for extension must be submitted in writing to the RARSS prior to expiration of the initial plan. The request must include:

- The same rooms and bed area.
- A revision to bring some, but not all, of the beds back into service.
- A revision to increase the number of non-available beds that includes all of the beds already designated as non-available.
- A change in the room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

The extension must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests.

Non-available bed plans expiring on or after October 1, 2004 will be limited to one 12 month extension. When a provider's initial or extended non-available bed plan ends, the nursing facility must return the beds to service or decertify the beds from Medicaid participation. Medicaid will not approve a non-available bed plan that substitutes beds elsewhere in the facility for the formerly non-available beds.

The nursing facility will not be eligible to submit a new non-available bed plan for 24 months following the expiration of the previously approved plan.

A provider may request a grace period after an extension if the provider can demonstrate progress to place the non-available beds into resident care service. The request for a grace period must be made to LTC Services. (Refer to the Directory Appendix of the Medicaid Provide Manual for contact information.) The request must specify the date that the beds will be available for occupancy and may not exceed 12 months. An example for such action is gradual facility renovation involving periodic non-available beds in a nursing unit and replacement with non-available beds in another unit as renovation plans progress.

The provider must meet all appropriate certification requirements for distinct part units for the remaining Medicaid beds. Additional beds may have to be decertified in order to meet the distinct nursing unit requirements. The nursing facility may request re-certification of these beds for Medicaid participation after a 24 month time period. A request to re-certify must meet all current Medicaid certification requirements.

9.13.D Change of Ownership (CHOW)

The non-available bed plan approval expires with a change of ownership of the nursing facility. If the new owner wishes to continue the non-available bed plan, they must submit a written request to the RARSS within 90 days of the CHOW. A non-available bed plan submitted after the 90-day period will be considered a new request and must satisfy the qualifying criteria and related policy requirements. If the new owner does not request continuation of the existing plan, the beds will be deemed available for occupancy effective with the date of ownership change

The new owner may apply to extend the plan to coincide with its cost reporting period by following the extension request policy outlined in the Life of an Approved Plan subsection. The nursing facility change of ownership does not relieve the nursing facility from the restrictions for non-available bed designation limitations for plan extensions other than allow for coinciding with the cost report year of the new ownership.

9.13.E Amending a Plan

The nursing facility may amend an approved non-available beds designation by submitting a written request to the RARSS. (Refer to the Directory Appendix for contact information.) A non-available beds plan may be amended only one time during a nursing facility cost reporting time period. A request for an amendment must include the same information as an initial request and will be reviewed using the same criteria. A plan amendment increasing the number of non-available beds is subject to the minimum time period requirement and the designation of all the beds must be effective for the time period of not less than the balance of the provider's current fiscal cost reporting year in which the beds are deemed non-available plus the following fiscal cost report year.

9.13.F. Penalty for Use of Non-Available Beds

Admitting residents to any beds in the area designated non-available for occupancy, regardless of payer source, before the end of the plan negates the plan retroactive to the beginning of the nursing facility's fiscal cost reporting period. All beds covered by the negated non-available bed agreement will be considered available for patient care for the entire cost report period.

9.13.G. Returning Beds to Service

All of the beds in the non-available bed plan will be considered returned to service and available for occupancy when the non-available bed plan expires.

In special circumstances, such as a sudden increase in demand due to closure of a nearby facility, non-available beds may be returned to service before the end of the approved plan with prior approval of the RARSS. A nursing facility with an approved non-available beds plan may submit a written request to return beds to nursing care if the individual nursing facility experiences the need for the beds due to the exception circumstances. The request must identify the reason for the need and the specific beds and room designations being made available. RARSS will provide immediate review and response to the nursing facility request.

9.13.H. Plant Cost Certification

A provider with an approved non-available beds plan has the option to submit to a Plant Cost Certification for the cost report fiscal period in which the beds are approved as non-available for occupancy or the termination of the plan. Refer to the Plant Cost Certification Section in this chapter for additional information.

9.13.I. Cost Reporting

The variable and plant costs attributed to the area designated as non-available and the related capital asset cost are not Medicaid reimbursable costs. The non-available rooms and bed numbers must be reported as a Non -Available Beds cost center on the provider's Medicaid cost report.

Each general service cost center must be evaluated separately to determine if the non-available bed area benefits from the service. The nursing facility may charge specific costs to the Non-Available Beds cost center only when the dollar amount is identifiable. Costs that cannot be specifically identified must be apportioned to the non-available beds cost center using the Medicaid cost report allocation methodology. The statistic or measure used for the general services cost center must also be used to allocate costs to the non-available bed cost center. For example, if square feet are used to allocate costs to the housekeeping activity the general services cost center, then square feet must also be used to allocate costs to the non-available bed area. The allocation to the non-available bed cost center is zero when the non-available bed area receives no benefit from the general service. For example, if a wing is designated as non-available and does not receive any housekeeping services, then the allocation to the non-available cost center is zero.

The reduction in available beds is included in the provider's cost report effective for the fiscal period in which the non-available bed plan is approved by the RARSS. For Medicaid reimbursement determination of tenure and allowable average borrowings, the percentage of the total plant asset costs applicable to available beds must equal the percentage of the facility remaining available for resident nursing care. .

9.14 Memorandums of Understanding (MOU) – Special Agreements for Complex Care

Memorandums of Understanding (MOU) – Special Agreements for Complex Care provide Medicaid reimbursement for residents receiving specialized services. Separate cost records are not required for identifying these costs. The Program has designated the special care revenue amount equal to cost. Providers with an MOU must adjust the annual Medicaid cost report by removing from the appropriate nursing care costs the dollar amount of the total difference between reimbursement at the special care rate and the established routine Medicaid rate. The rate provisions are identified in the provider's memorandum of understanding issued with the placement of the special care resident in the facility.

SECTION - 10 RATE DETERMINATION

There are six classes of nursing care facilities for which there are specific reimbursement methods. For a definition of the six classes, refer to the Definitions section in this chapter. Providers reimbursed for care using a special reimbursement calculation or method are addressed at the end of this section.

The determination of a nursing facility's class is made by the State Survey Agency. If a nursing facility changes ownership or the services it provides such that a change in class is appropriate, the facility will be reimbursed according to the respective facility class to which it has been changed. The effective date of the reimbursement change is the effective date of the State Survey Agency's determination. Nursing facility providers other than Class IV are reimbursed under a methodology that pays the lower of the customary charge to the general public or a prospective payment rate determined by Medicaid.

Payment rates described in this section refer to the provider's prospective per resident per diems, and are generally set 30 days in advance of the State's fiscal year, which is October 1 through September 30. (Rate determination timing is dependent on legislative approval of the Department of Community Health's budget.)

NOTE: The charts in the Nursing Facilities Reimbursement Appendix, Attachment C, illustrate the timeline and calculations for per diem rate setting.

Prospective payment rates are calculated using the facility's cost report ending in the previous calendar year. If this cost report covers a time period that is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months.

The reimbursement rate determination process uses a provider's most recent fiscal period audited cost data to calculate the routine nursing care per diem rate. If audited data is not available, an interim prospective rate is calculated using the filed cost report, if the cost report was acceptable and was filed with Medicaid within five months from the end date of the cost reporting period. If an acceptable cost report was not filed within this time frame, Medicaid is not required to set the prospective payment rate in advance of the State's fiscal year. If the nursing facility did not file within the five month time period, or has amended an original cost report subsequent to the five month period, Medicaid will calculate the prospective rate for an effective date for services no later than the beginning of the fourth month (January 1) of the State fiscal year. Nursing facilities that are required to file an amended cost report in order to include home office costs that were not included in the original cost report due to the difference in cost reporting period from the home office are exempt from this provision. The amended cost report, if filed timely following the completion of the home office cost statement, will be considered timely filed if the original cost report had met the five month filing requirement. Refer to the Cost Classification and Cost Finding section of this chapter for home office cost statement and nursing facility amended cost reports.

10.1 RATE DETERMINATION PROCESS

The per diem reimbursement rate for Class I and Class III nursing facility providers is made up of three components: a plant cost component, a variable cost component, and add-ons.

- For Class I facilities, the plant cost component is made up of the Property Tax/Interest Expense/Lease Component plus the Return on Current Asset Value Component.

- For Class III facilities, the Plant Cost Component is the lesser of the Facility Per Patient Day Plant Cost or the Facility Plant Cost Limit. The Facility Plant Cost Component is the depreciation, interest and lease expenses calculated on a per patient day basis.
- For Class I and Class III facilities, the Variable Cost Component is made up of the facility's Variable Rate Base plus the Economic Inflationary Update.

Class II facilities, being proprietary nursing facilities for the mentally ill or mentally retarded, are reimbursed an all-inclusive prospective payment rate negotiated with the MDCH State Mental Health Agency on an annual basis. Final reimbursement is retrospective cost settlement, not to exceed a ceiling limit. The provider may be eligible for a reimbursement efficiency allowance in the final rate if total allowable costs do not exceed the prospectively established ceiling limit.

Class IV facilities, being state-owned and operated institutions, Intermediate Care Facilities for the Mentally Retarded (Developmentally Disabled), and non-profit nursing facilities for the mentally retarded, are reimbursed allowable costs determined in accordance with Medicare Principles of Reimbursement and are retrospectively cost settled.

Per diem rates for Class V facilities, Ventilator Dependent Care Units, are set prospectively. Services included in the per diem rate are outlined by contract with Medicaid.

Payment rates for Class VI Hospital Swing Beds are set prospectively as a flat per resident day rate determined by Medicaid.

10.2 Retroactive Rate Changes

A retroactive change may be made for facilities that have interim prospective rates based on filed cost reports. A retroactive change may be made for:

- audit adjustments to a filed cost report that was used for setting an interim rate.
- facilities that were approved for Plant Cost Certification due to capital cost changes, an approved unavailable bed plan, or a plant rate affected by a DEFRA rate limitation for the cost report time period.
- facilities that were retrospectively settled because they were granted Emergency Rate Relief.
- audit adjustments that are required as a result of an appeal.
- audit adjustments that are required as a result of fraud or facility failure to disclose required financial information.
- Class I nursing facilities approved for Rate Relief for the rate year period.

The Plant Cost Component of a rate for the nursing facility that experiences a change of ownership will be retroactively adjusted under the Plant Cost Certification process. The DEFRA Reimbursement Limit application will continue to apply to each rate year until a fiscal year retrospective rate change results in zero DEFRA limit. The nursing facility Plant Cost Component will be calculated on a prospective basis for the year following the zero DEFRA limit rate year.

10.3 Plant Cost Component Class I Nursing Facilities

The prospectively established Plant Cost Component for each Class I nursing facility provider is the sum of the facility Net Property Tax/Interest Expense/Lease Component and Return on Current Asset Value Component. The Plant Cost Component is expressed as a per patient day amount.

10.3.A. Net Property Tax/Interest Expense/Lease Component Per Patient Day

The Net Property Tax/Interest Expense/Lease Component per patient day is calculated under the following formula:

Property Tax/Interest Expense/Lease Plant Cost	-	CAV Excess Borrowing Limit	+	DEFRA Reimbursement Limit (not to exceed zero)	=	**Net Property Tax/Interest Expense/Lease Plant Cost**

Net Property Tax/Interest Expense/Lease Plant Cost	÷	Nursing Facility Resident Days	=	**Net Property Tax/Interest Expense/Lease Plant Cost Per Patient Day**

10.3.A.1 Property Tax/Interest Expense/Lease Plant Costs

These plant costs consist of allowable costs for real estate and personal property taxes, interest expense, and lease expense, defined under the allowable and non-allowable cost section and cost classification section of this chapter. The aggregate dollar amount for these plant costs is obtained from the nursing facility cost report. The time period of the cost report will correspond with the cost basis period identified for the respective State rate year.

10.3.A.2 CAV Excess Borrowings Limit

The dollar amount of allowable interest expense included in the reimbursable plant cost will be reduced if the nursing facility loan balance applicable to the nursing care unit exceeds the facility reimbursement limit. The nursing facility's average allowable borrowing balance cannot exceed the lesser of the "Nursing Facility Current Asset Value" or the "Nursing Facility Capital Asset Value Limit." If the nursing facility borrowing balance exceeds the limit, a reduction is made to the allowable plant cost for the portion of the excess borrowing. The amount of the reduction is based on the ratio of the limit amount to the average borrowings balance times the dollar amount of allowable interest expense. The following formula is applied to calculate the reduction:

Lessor of (NF CAV) or (NF CAV LIMIT)	÷	Facility Average Borrowing Balance	x	Allowable Interest Expense	=	**CAV Excess Borrowings Limit**

A nursing facility that has undergone a change of ownership and is incurring interest costs relating to the acquisition financing will be subject to a DEFRA disallowance. The DEFRA disallowance calculation will determine if the nursing facility acquisition and financing costs exceed Medicaid allowable reimbursement increase. If the nursing facility has a DEFRA Reimbursement Limit due to the nursing facility acquisition, the nursing facility's total average borrowing balance used in the calculation for CAV excess borrowings limit will be reduced by a calculated dollar amount of borrowings corresponding with the DEFRA Reimbursement Limit. This reduction to the facility total borrowing balance is made to avoid including the borrowing balance amount both in the DEFRA limit and the CAV excess borrowing limit. The borrowing amount corresponding with the DEFRA Reimbursement Limit is calculated under the following formula:

Dollar Amount of DEFRA Reimbursement Limit	÷	Nursing Facility Total Allowable Interest Expense	X	Nursing Facility Average Borrowing Balance	=	**Reduction to NF Average Borrowing Balance**

The dollar amount resulting from this calculation will be the amount of the reduction to the nursing facility average borrowing balance for comparison to the Nursing Facility CAV or Nursing Facility CAV Limit.

10.3.A.3 DEFRA Reimbursement Limit

Increases in reimbursement for tenure and interest expense subsequent to a sale or resale (after July 18, 1984) are limited under provisions of the Deficit Reduction Act (DEFRA) of 1984 as defined in federal Medicaid law. The Medicaid application of DEFRA provisions is a limit on the dollar amount of plant cost component reimbursement increase to the Provider due to the nursing facility change of ownership. An established formula calculation is used to determine the new ownership's eligible increase reimbursement for tenure and interest (DEFRA Application Limit). If the new ownership tenure and interest before application of the DEFRA Reimbursement Limit and Excess Borrowing Limit does not exceed the allowable increase, the DEFRA Reimbursement is not applicable. If the new ownership tenure and interest before application of the DEFRA Reimbursement Limit and Excess Borrowing Limit exceeds the allowable increase, the DEFRA Reimbursement Limit reduction will be made to the allowable plant costs.

The calculation is made as follows:

DEFRA Application Limit	-	Increase in tenure and interest for new ownership prior to DEFRA Limit or Excess Borrowing Limit	=	DEFRA Reimbursement Limit (not applicable if greater than zero)

DEFRA Application Limit is determined as:

Allowable historical capital asset cost to the asset original owner (excluding land), for assets in the NF at the time of sale	x	3.3333%	+	Allowable land value to the seller	+	Historical capital asset cost of the asset's original owner for assets in the nursing facility at the time of sale	-			
Purchaser down Payment	X	Purchase Mortgage interest rate.	-	Allowable interest expense of the seller for the rate period prior to the sale	=	DEFRA Application Limit				

Increase in tenure and interest for the new ownership prior to DEFRA Limit or Excess Borrowing Limit is determined as:

Purchaser tenure and allowable interest after the sale	-	Seller tenure and allowable interest in the Medicaid rate prior to the sale	=	Purchaser tenure and allowable interest after the sale.

The calculation formula is defined for application when using annualized cost data (reflective of twelve month time period). If all of the data elements needed in the calculation do not include data for a twelve month period, the data elements must be adjusted to reflect a time period of equal duration to the cost report base period used in determining the "purchaser tenure and allowable interest after the sale."

The DEFRA Reimbursement Limit continues to apply to the new ownership annual Property Tax/Interest Expense/Lease Component rate using the Plant Cost Certification reimbursement settlement procedure until the limit amount is zero.

10.3.B Return on Current Asset Value (CAV) Component

The Return on Current Asset Value Component is a per resident day amount representing a use allowance on facility assets. The return amount is determined by multiplying the "tenure factor" times a CAV calculated for the nursing facility. A nursing facility's CAV is determined by a formula using historical costs of the nursing facility's capital assets, as identified in the Allowable and Non-Allowable Costs section in this chapter, times the difference between an asset value update factor and an obsolescence factor. Assets purchased prior to 1960 are treated as assets brought into service in 1960. A nursing

facility's CAV for rate reimbursement calculation cannot exceed the "current asset value upper limit" and will not be less than the "current asset value floor."

The calculation for the return on current asset value component is:

Lesser of NF CAV or NF CAV Limit	x	Tenure Factor	=	Total NF Return on CAV

Total NF Return on CAV	÷	NF Resident Days	=	Return on CAV Component Per Resident Days

10.3.B.1 Asset Value Update Factor

The asset value update factor used to calculate CAV depends on the type of capital asset. Land improvements, buildings, building improvements, and fixed building equipment are updated, using the Marshall Valuation Service Construction Cost Index for Class A Buildings in the Central United States, from the fiscal year the asset was brought into service until the most recent period for which cost report data is available for the respective rate year calculation. The asset value update factor is not applied to land and other assets not specifically listed above.

10.3.B.2 Asset Value Obsolescence Factor

The obsolescence factor is applied based on the classification category of the capital asset. Land has an obsolescence factor of zero. Land improvements, buildings, building improvements, and fixed building equipment have an obsolescence factor of .03 for each year the asset has been in service. Movable equipment and other capital assets have an obsolescence factor of .10 for each year the asset has been in service up to a maximum of 10 years. The number of years that the asset has been in service is determined by subtracting the year the asset was put into service from the most recent fiscal year for which data is available under standard rate setting timeframe.

10.3.B.3 Current Asset Value Formula

A nursing facility's CAV is determined by a formula using historical costs of capital assets. The current asset value for each asset is the historical cost of that asset times the difference between its Asset Value Update Factor and its Asset Value Obsolescence Factor. Assets purchased prior to 1960 are recorded as assets brought into service in 1960. Current asset values are updated annually based on the most recent audited or reviewed cost report. A nursing facility's current asset value is the sum of current asset values for the various asset types.

Example: Building assets with historical cost of $100,000 in service for 10 years through the cost report year used in the rate calculation; the update factor for the 10

years is 1.50; obsolescence factor is .30 (10 years times .03); the amount included in the CAV compilation for the nursing facility for these assets is $120,000 [$100,000 times (1.50 minus .30)].

If the nursing facility Plant Cost Component is calculated based on Plant Cost Certification data, the new capital assets acquired in the current cost report year and the immediate prior cost report year will be included in the nursing facility historical asset costs for compiling the CAV. The update factor for these assets will be 1.0, and the obsolescence factor will be zero.

10.3.B.4 Nursing Facility Current Asset Value

The current asset value calculation process determines a CAV for the entire nursing facility since capital assets are used for all types of services delivery in that facility. Only the portion of the nursing facility assets having a use related to routine nursing resident care are included for reimbursement under the return on current asset value component. The reference to Nursing Facility CAV is defined as the nursing unit portion of the nursing facility's total current asset value applicable to routine nursing care. The apportionment, expressed as a percentage, of a total facility that is applicable to the routine nursing care unit is determined by means of the facility's annual cost report. The SMA cost reporting process apportions the nursing facility asset costs into the appropriate cost centers for reimbursement purposes.

The Nursing Facility CAV is calculated as:

Total CAV for the NF	x	Percentage representing the nursing unit apportionment	=	NF CAV

10.3.B.5 Class I Nursing Facility Current Asset Value Limit Per Bed

The current asset value upper limit is a maximum per bed dollar amount that will be used for calculating the individual Nursing Facility CAV. The per bed value of the upper limit is based on the historical costs of construction and other asset acquisition costs for nursing facilities opened on or after January 1, 1975. The historical costs are updated through 1983 using the U.S. Department of Commerce Composite Construction Index, and annual updates after 1983 are made using the Marshall Valuation Service Construction Cost Index for Class A Buildings. The update index does not apply an obsolescence factor. The current asset value limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. The current asset value limit is recalculated annually to include construction costs of new facilities reported in the most recent calendar year filed cost reporting and the construction index update. The per bed upper limit is effective for the time period corresponding to the State rate year.

The current asset value floor is 30 percent of the current asset value upper limit.

Class I nursing facility current asset value limits per bed for each rate year are available on the MDCH website. Refer to the Directory Appendix of the Medicaid Provider Manual for website information.

10.3.B.6 Nursing Facility Current Asset Value Limit

A current asset value limit is determined by the individual nursing facility and is dependent on the number of beds in the Medicaid nursing unit for the time period corresponding with the respective rate effective date. The current asset value upper limit is a maximum dollar amount for the individual Nursing Facility CAV that will be used for calculating the return on current asset value. The Nursing Facility CAV Limit is the number of available beds in the nursing unit times the Class Current Asset Value Limit Per Bed.

The current asset value floor limit is a minimum dollar amount for CAV that will be used for calculating the return on current asset value for that nursing facility. The individual Nursing Facility CAV floor is the Nursing Facility CAV Limit times 30 percent.

10.3.B.7 Tenure Factor

The tenure factor is dependent on the nursing facility provider's number of full years of continued licensure as of the beginning of the Medicaid rate year, i.e., months of continuous licensure divided by 12 and ignoring fractions.

Continued licensure is based on the number of full years that have elapsed from the effective date of a nursing facility provider's license (issued by the State Survey Agency) to the beginning of the Medicaid rate year. For example, a provider that has been licensed for 42 continuous months has, for purposes of the tenure factor, been licensed for 3 full years. The provider's years of ownership are translated into a tenure rate, and applicable rates are identified in the following table.

Years of Ownership At Start Of Provider Fiscal Year	Rate of Return on Current Asset Value
0-1	.0250
2	.0275
3	.0300
4	.0325
5	.0350
6	.0375
7	.0400
8	.0425
9	.0450
10	.0475
11	.0500
12 or more	.0525

The rate of return on current asset value is expressed as an annual return rate. Qualification for the total return rate requires that the time period included in the nursing facility cost report used as the basis for the facility plant cost rate include twelve calendar

months. In cases where the nursing facility cost report does not include twelve calendar months, the following formula is used to calculate the return rate:

Number of calendar days in the cost report period	÷	365	X	Rate of return on CAV (for the respective years of owndership)	=	**Return Rate**

Example: A nursing facility has 7 years of ownership and the cost report period used for plant costs in the rate calculation is for a 9 month time period (263 days). The adjusted return rate is .0288 (263/365 times .0400).

If a nursing facility is sold or totally replaced (regardless of facility ownership), years of ownership return to zero. If a facility is remodeled or expanded and facility ownership remains unchanged, the years of ownership remain continuous.

When licensure has changed but there has been no effective change in operator/provider, and there has been no transaction that would affect Medicaid reimbursement other than the tenure factor, the provider may request that Medicaid recognize the continuous tenure such that the licensure tenure schedule would not revert to zero years at the time of the licensure change. The provider's written request must be submitted at the time licensure is changed.

Exception: Where licensure does not change after a sale of nursing facility assets, the nursing facility provider (new owner) must choose either to retain the original licensure tenure schedule and forego increased reimbursement for interest expense, or to receive increased reimbursement for interest expense, subject to the DEFRA Reimbursement Limit, and allow the licensure tenure schedule to revert to zero years and a tenure factor of .0250. Should the provider elect to retain the previous licensure tenure schedule, Medicaid will not recognize, for allowable cost and per diem rate determination purposes, any interest expense beyond the schedule of borrowings, principal amortization, and interest expenses that would have been incurred were the former owner's loans maintained or assumed by the new owner. This provision applies to all property transactions between lessors, lessees, and/or operators.

10.4 Plant Cost Component Class III Nursing Facilities

The prospectively established plant cost component for each county medical care facility provider and hospital long term care unit provider is the lesser of the allowable per resident day facility plant cost or the per resident day facility plant cost limit. Proprietary providers are permitted to retain, as part of the plant cost component, up to $.50 of the difference between allowable per resident day plant costs and the per resident day plant costs in effect on March 31, 1985 ($5.66 per resident day).

10.4.A. Facility Plant Cost Per Resident Day

The allowable per resident day plant cost is the sum of depreciation expense, interest expense, property taxes, and allowable lease costs divided by total resident days as determined from the provider's cost report. A facility with a change in facility asset costs may qualify for plant cost limit updates.

10.4.B. Facility Plant Cost Limit Per Resident Day

The individual provider facility Plant Cost Limit is dependent upon when facility beds were constructed and brought into service for Medicaid residents. Nursing facilities existing prior to July 1, 1978 were initially assigned the facility Class Plant Cost Limit for new construction as of that date. A nursing facility constructed after that date is initially assigned the facility Class Plant Cost Limit effective in the year facility beds are constructed and brought into service for Medicaid.

A facility's Plant Cost Limit, expressed as per resident day, is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The individual nursing facility Plant Cost Limit is updated for a nursing facility that undergoes a significant change in facility asset costs. The nursing facility must complete the Plant Cost Certification process to qualify for consideration of the update to the individual facility Plant Cost Limit. The provider nursing facility must meet the qualifying provisions for Plant Cost Certification eligibility other than non-available bed designation or returning non-available beds to service, to be eligible for a revised plant cost limit. The non-available bed plan designation criteria does not qualify the nursing facility for an update to the facility plant cost limit. An existing provider with a change of facility class, major addition, renovation or new construction may be eligible for a Plant Cost Limit update to reflect the change in facility asset costs. An existing facility that chooses to become a Medicaid-participating provider may also qualify for an updated plant cost limit.

The updated plant cost limit is applicable to a nursing facility dependent upon the facility's capital asset project. A nursing facility that is a total new construction, a facility that incurs major capital asset renovation and/or addition, a facility newly participating in the Medicaid program, or a facility that experiences a change in facility class is eligible for updated depreciation, interest, finance fee and property tax components for the facility Plant Cost Limit. The update in the limit is based on a compilation of the facility limit prior to the capital asset change and the Class Plant Cost Limit.

The individual facility updated Plant Cost Limit effective with the completion of the capital asset project is a weighted average of the historic individual facility Plant Cost Limit for the portion of the facility prior to the new construction and the current Class Plant Cost Limit applicable to the new capital asset project. The weighting factors used are the respective ratios of the allowable historic asset costs of the facility prior to the new construction, and the allowable asset costs of the new construction, to the combined allowable old and new asset costs of the nursing facility after construction. The current Class Plant Cost Limit used in the weighted calculation applicable to the new capital cost portion will be the class limit in effect for the year corresponding to the new asset acquisitions being placed into service.

Nursing facility providers that incur a capital asset change resulting from a facility sale of assets will use as a plant cost basis only those allowable costs identified in the Allowable and Non-Allowable Costs section in this chapter. The individual nursing facility updated Plant Cost Limit after the sale is only eligible for an update for the interest expense component limit to reflect changes in interest rates.

10.4.C. Facility Class Plant Cost Limit Per Resident Day

The Class Plant Cost Limit is the maximum reimbursement rate, expressed as per resident per day amount, for a provider nursing facility new construction. The Class Plant Cost Limit is applicable to new construction nursing facilities dependent upon when facility beds were constructed and brought into service for Medicaid residents. The Class Plant Cost Limit is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The Class Plant Cost Limit components are updated annually to reflect changes in industry construction cost, interest rates and corresponding effect on financing fees and real estate taxes due to changes in capital costs. The new construction limit is used in determining the individual nursing facility limit in cases where the nursing facility is an entire new construction or an existing nursing facility has completed a significant capital cost improvement.

The per resident day Class Plant Cost Limit is the amount that would be paid for a recently constructed and prudently financed facility. Calculation of the plant cost limit is based on a survey of nursing facilities constructed between January 1, 1975 and December 31, 1977, and initially updated to June 30, 1978. The original Class Plant Cost limit individual components are updated annually using published economic indicators identified in the sub-sections addressing the specific component of the limit. The Class Plant Cost Limit annual updates are available on the MDCH website. Refer to the Directory Appendix of the Medicaid Provider Manual for website information.

10.4.C.1. Facility Class Plant Cost Limit Depreciation Expense Component

The value for the depreciation expense component is a sum based on the mean of the surveyed values of depreciable assets (referenced above) and the mean depreciation rate for assets of similar type using straight-line depreciation with useful lives determined in accordance with Medicare Principles of Reimbursement. The per resident day depreciation expense component is updated each calendar quarter to reflect the change in costs of construction and changes in standards and regulations which have a direct impact on plant costs. The depreciation component is updated using the economic index release as published under U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Tables, for Nonresidential Structures.

10.4.C.2. Facility Class Plant Cost Limit Interest Expense Component

The value for interest expense is based on the surveyed mean of interest rates paid (referenced above) and the mean asset values for facilities constructed during the initial 3-year survey time period. The per resident day interest component is updated annually based on the changes in interest rates. The interest rate data used to calculate the

interest component limit is updated by applying an index of change in interest rates for home mortgage loans (reflected in conventional new home mortgage rates, as published by the Federal Housing Finance Board for Newly Built Homes) to the interest rate used to calculated the original interest component limit.

A nursing facility that undergoes a change of ownership is eligible for an update to the individual facility Plant Cost Limit. The update will only include an adjustment to the interest component of the individual facility Plant Cost Limit in effect prior to the sale. The adjustment will be made to the interest component of that prior limit to reflect the change in the interest rate index between the time period reflected in the prior limit calculation and the date of the facility sale.

10.4.C.3 Facility Class Plant Cost Limit Financing Fees Component

The value for financing fees is based on the mean of financing fees of the surveyed construction (referenced above). The per resident day financing fees component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original financing fees component limit.

10.4.C.4 Facility Class Plant Cost Limit Tax Expense Component

The value for property taxes is based on the mean of property taxes of the surveyed taxable properties (referenced above). The per resident day property tax component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original property tax component limit.

10.5 Variable Cost Component (VCC) – Class I and Class III Facilities

The variable cost component of the nursing facility per resident day rate reflects the Medicaid determination for reimbursement for the nursing facility base and support costs incurred for routine nursing care. Base and support cost classifications are discussed in detail in the Cost Classifications and Cost Finding subsection of this chapter. The calculation of the component uses nursing facility historical costs and economic index application to adjust cost levels to coincide with the State rate year time periods. The support costs and total variable (base plus support) costs are separately subjected to rate ceiling reimbursement limits dependent on individual facility bed size and facility class.

For Class I and Class III nursing facility rate setting periods beginning on or after October 1, 2003, the Variable Cost Component is a per resident day rate and is equal to the lesser of the facility's Variable Rate Base (VRB) OR the Class Variable Cost Limit (VCL), plus the Economic Inflationary Update (EIU).

VCC = (lesser of VRB or Class VCL) + EIU

10.5.A. Variable Rate Base (VRB)

The facility Variable Rate Base is the sum of the facility's indexed base cost component and the facility's indexed support cost component. For rate setting purposes, the per

resident day amount used for the provider's Variable Rate Base is the lesser of the calculated Variable Rate Base or the Class Variable Cost Limit.

VRB = Base Cost Component + Support Cost Component

10.5.A.1 Base Cost Component (BCC)

A facility's BCC is the facility per patient day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.

BCC = (base costs/total number of resident days) X Cost Index

Facility's base cost per day - the facility base costs divided by the total number of resident days for the cost reporting period.

10.5.A.2 Support Cost Component (SCC)

A facility's support cost component is the facility's BCC multiplied by the lesser of the facility's support to base ratio or the support-to-base ratio limit for that nursing facility bed-size group.

SCC = BCC X applicable S/B ratio (Facility or Bed-Size Group Limit)

- Facility's support cost per day - the facility support costs divided by the total number of resident days for the cost reporting period.
- Facility Support-To-Base Ratio (S/B-Facility) - the nursing facility allowable support costs divided by the allowable base costs for the cost reporting period. The individual Provider's S/B ratio for rate calculation is limited to the Support-To-Base Ratio Bed Size Group Limit for the Provider's bed-size group. The individual nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The Provider's S/B ratio is rebased annually from the most recent audited cost period, regardless of ownership.
- Support-To-Base Ratio – Bed Size Group Limit (S/B-Group) – the 80th percentile of the support-to-base ratios for nursing facilities in the same bed-size group for a cost reporting year. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the nursing facility. The nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The 80th percentile is determined by rank ordering the provider nursing facilities within the same bed-size group from the lowest to highest S/B ratio, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this group of providers is reached. The S/B ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid days occurs.

10.5.B. Cost Index (CI)

A facility cost index is the Global Insight's Skilled Nursing Facility Market Basket without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index will be used to index reported costs from the end of the facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated.

Example: Cost report data used to set reimbursement rates for the October 1, 2003 to September 30, 2004 rate year will be indexed to October 1, 2002.

10.5.C. Class Average of Variable Costs (AVC)

The Class Average Variable Cost is defined as the total indexed variable costs for all facilities in the Class divided by the total resident days for all facilities in the class for a cost reporting year. An AVC is calculated for Class I and Class III nursing facilities. The Class AVC is used for rate calculations for nursing facilities that meet the qualifying criteria as a new provider for Medicaid participation and determining provider eligibility for Class I nursing facility rate relief.

AVC = (total Indexed Variable Costs for all NF's in the class) /
(total resident days for all NF's in the class)

- Facility's Variable Costs (VC) - the total allowable base and support costs for a facility to provide routine nursing care services to residents, as determined in accord with Medicaid allowable costs and reporting requirements.
- Indexed Variable Costs (IVC) – the facility's total VC indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The AVC for October 1, 2003, which is used for the rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports ending in calendar year 2002 indexed to October 1, 2002.

10.5.D. Class Variable Cost Limit (VCL)

The Variable Cost Limit for a class of nursing facilities is set at the 80th percentile of the Indexed Variable Costs (IVC) per resident day for facilities in the class during the current calendar year. The 80th percentile is determined by rank ordering providers from the lowest to the highest IVC per resident day, then accumulating nursing facility Medicaid resident days of the rank ordered provides, beginning with the lowest, until 80 percent of the total Medicaid resident days for the facility class of providers is reached. The VCL for the class of providers equals the IVC per resident day of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities.

- Facility's Variable Cost per resident day (VC/pd) - the facility VC divided by the total number of resident days for the cost reporting period.

- Indexed Variable Costs Per Resident Day (IVC/pd) – the facility's VC/pd indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The VCL for October 1, 2003, which is used for the rate year October 1, 2003 to September 30, 2004, is based on variable costs per resident day reported in cost reports ending in calendar year 2002 indexed to October 1, 2002.

10.5.D.1 Class I Nursing Facility VCL Exception - New Provider Rate Relief

A Class I nursing facility that qualifies for rate relief as a new provider, as defined for rate relief, in a Medicaid enrolled nursing facility with a VRB less than or equal to 80% of the class AVC will have an exception VCL in the rebasing rate year. The rate Variable Cost Component for the initial rate year of accelerated rebasing is limited to the Class I Average of Variable Costs. Refer to the Rate Relief for Class I Nursing Facilities subsection in this chapter for additional information.

10.5.D.2 Class III Nursing Facility VCL Exception – New Hospital Long Term Care Units After July 1, 1990

Class III nursing facilities that are new long term care units of a hospital, and have a Certificate of Need (CON) approval from the Michigan Department of Community Health (MDCH, formerly Department of Public Health) dated on or after July 1, 1990, are reimbursed according to the method for Class III facilities except that the facility Variable Cost Component is determined as the lesser of the facility Variable Rate Base or the Class I Variable Cost Limit (VCL).

10.5.E. Economic Inflationary Update (EIU)

The economic inflationary update for a facility is the Economic Inflation Rate (EIR) for the class applied to the lesser of the Variable Rate Base or the Class Variable Cost Limit.

EIU = EIR X (lesser of VRB or Class VCL)

Economic Inflation Rate (EIR) - the State legislative appropriations process will determine the annual economic inflation percentage for Class I and Class III nursing facilities.

10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units

The reimbursement rate for special nursing facilities caring for ventilator-dependent residents (Class V) is set prospectively as an individual nursing unit all-inclusive rate per resident day determined by Medicaid.

Reimbursement is made for prior authorized ventilator-dependent services/care for residents who have been transferred from an acute care hospital setting to a qualifying special nursing facility. The prospective rate covers all care requirements of the residents, including all the costs of benefits associated with Medicare Parts A and B while the resident resides in the special nursing facility. This includes, but is not limited to, all routine, ancillary, physician, and other services.

Factors used in the determination of the all-inclusive per diem rate include audited costs of facilities providing similar services, the inflationary factor for the effective period of the prospective rate, the supply response of providers, and the number of residents for whom beds are needed. The prospective rate does not exceed 85 percent, nor fall below 15 percent, of an estimated average inpatient hospital rate for currently placed acute care Medicaid residents who are ventilator-dependent. The prospective rate is periodically re-evaluated to ensure reasonableness of supply and demand for special care. A new VDC nursing unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years of operations based upon the statewide average VDC unit reimbursement rate for the current year.

10.7 Nursing Facility Quality Assurance Assessment Program (QAAP)

The Quality Assurance Assessment Program (QAAP) was implemented by Medicaid in compliance with Michigan law. The QAAP provides a Quality Assurance Supplement to nursing facility reimbursement rates incorporating funds from the quality assurance assessment tax. The QAAP applies to Class I, Class III Non-Publicly Owned, and Class V nursing facilities.

10.7.A. Class I Nursing Facilities and Class III Non-Publicly-Owned Hospital Long-Term Care Units

The nursing facility will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on one-twelfth of the facility's annual historical Medicaid utilization (resident days) multiplied by the facility's Quality Assurance Supplement (QAS) per resident day. The facility's historical Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility. A nursing facility that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent (5%) in the nursing facility's total QAS payments for the year must contact the SMA for consideration of adjustment to the facility's monthly QAS payment. Current year Medicaid resident census data must be provided to MDCH to document the change in order to make revision to the monthly QAS payment amounts. It is the desired intent of MDCH to assure accuracy of total QAS monthly payments to approximate the annual reimbursement due the facility. MDCH reserves the right to adjust the individual nursing facility monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

A facility's QAS is equal to the lesser of the facility's Variable Rate Base or Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDCH. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization, changes to the variable rate from filed to audited cost report data, and to adjust the increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment fee may not exceed 6% of total industry revenue for the fiscal year.

10.7.B. Class V Nursing Facilities - Ventilator Dependent Care (VDC) Units

Qualifying VDC units will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual unit will be determined based on one-twelfth of the VDC unit's annual historical Medicaid utilization (resident days) multiplied by the unit's Quality Assurance Supplement (QAS) per resident day basis. The unit's Medicaid utilization will include all days billed to Medicaid by the VDC unit. A nursing unit that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent (5%) in the nursing unit's total QAS payments for the year must contact MDCH for consideration of adjustment to the unit's monthly QAS payment. Current year Medicaid resident census data must be provided to the SMA to document the change in order to make revision to the monthly QAS payment amounts. It is the desired intent of MDCH to assure accuracy of total QAS monthly payments to approximate the annual reimbursement due the VDC unit. MDCH reserves the right to adjust the individual VDC unit monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

The VDC unit QAS is equal to the Class I Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDCH. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization and to adjust the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment tax may not exceed 6% of total industry revenue for the fiscal year.

10.8 Class II Nursing Facilities – Proprietary Nursing Facility for the Mentally Ill or Mentally Retarded

The Class II proprietary nursing facilities for the mentally ill or mentally retarded are reimbursed an all-inclusive prospective payment rate negotiated with the MDCH State Mental Health Agency on an annual basis. Rate ceiling limits are prospectively set for allowable costs and resident occupancy for determining final reimbursement for the annual services. Final reimbursement is retrospective cost settlement, not to exceed the ceiling limit. Nursing facility allowable costs included for reimbursement are determined in accordance with Medicaid cost reporting requirements and allowable and non-allowable cost policies, including plant cost based on allowable depreciation expense. The Provider is paid a reimbursement efficiency allowance equal to the lesser of $2.50 per resident day or the difference between the prospective ceiling limit and the nursing facility actual allowable cost.

10.9 Class IV Nursing Facilities – Institutions for the Developmentally Disabled

State-owned and operated institutions, Intermediate Care Facilities for the Mentally Retarded (Developmentally Disabled – ICF/MR), and non-profit nursing facilities for the mentally retarded are retrospectively cost settled.

The State Mental Health Agency must submit rate information regarding the facility's expected costs for the prospective year in an Interim Rate Request letter to Medicaid at the beginning of the Medicaid rate year. Subsequent requests may be submitted during the rate year if rate adjustments are necessary. The reimbursement rate for the new Medicaid rate year will not be updated until the State Mental Health Agency submits the Interim Rate Request letter.

The provider is reimbursed an interim per diem rate based on the cost information submitted. The interim reimbursement is adjusted to actual allowable costs through annual cost settlement. Refer to the Cost Report and Reimbursement sub-sections of this chapter for additional information.

10.10 Class VI Nursing Facilities – Hospital Swing Beds

The reimbursement rate for hospital Swing Beds (Class VI) is set prospectively as a flat per diem rate determined by Medicaid.

The current calendar year per resident day rate is the weighted statewide average routine nursing care per diem rate for the previous calendar year. The average routine nursing care per diem rate is calculated by dividing the sum of Medicaid amount approved for payment for routine nursing care in Class I and Class III facilities by the sum of nursing care days paid in these facilities for the respective time period. The reimbursement rate calculation does not include Quality Assurance Supplement (QAS) reimbursement.

10.11 Add-Ons

10.11.A. Special Dietary

Nursing Facilities Coverages and Limitations Chapter, Dietary Services and Food section provides for program reimbursement to non-profit nursing facilities for special dietary needs for religious reasons. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total special dietary add-on reimbursement to the nursing facility during the reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Report Reimbursement Settlement section of this chapter for additional information.

A qualifying nursing facility that has previous year cost history of special dietary costs will have the interim payment rate add-on based on special dietary cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate will be the source of the cost data for the current interim rate add-on.

A qualifying nursing facility that does not have previous year cost history of special dietary costs will have an interim reimbursement rate add-on based on estimated cost data. The nursing facility must submit a written request identifying the estimated costs to be incurred in food purchase and preparation associated with special dietary needs for religious reasons. The request must be submitted to the RARSS and must include a certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix of the Medicaid

Provider Manual for contact information.) The written request must present the following data for the current cost report year:

- Estimated resident days (not less than 85% occupancy rate for all nursing facility resident units)
- Estimated raw food purchase costs including a detail listing of the types of food to be purchased for special dietary needs for religious reasons.
- Estimated cost for supplies, tableware, cooking utensils, etc., for food preparation and service associated with special dietary needs for religious reasons.

The submitted data will be subject to review and adjustment by Medicaid for consideration and calculation of the interim rate and the add-on reimbursement rate to the facility. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.11.B. Nurse Aide Training and Competency Evaluation Program (NATCEP) Add-on

Nursing Facility Certification, Survey and Enforcement Chapter, Staff Certification section provides for nursing facility Medicaid reimbursement for Medicaid's share of costs incurred by the nursing facility for approved Nursing Aide Training and Competency Evaluation Program (NATCEP) expenditures. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total NATCEP add-on reimbursement paid to the nursing facility during the nursing facility's cost report reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Classification and Cost Finding section and Cost Report Reimbursement Settlement section of this chapter for additional information.

The interim rate add-on amount is limited to a maximum per diem of $0.80 per resident day, however the nursing facility cost reimbursement settlement for these training costs is not subject to a per diem limit. The interim payment rate add-on will reflect the nursing facility's prior year cost history of NATCEP costs utilizing the NATCEP cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate is the source of the cost data for the current interim rate add-on, except where a more recent interim reimbursement request has been submitted by the nursing facility.

Effective October 2005m the interim rate add-on amount is increased to $1.00 per resident day.

A nursing facility that is notified by the State Survey Agency of loss of NATCEP or CEP, has been placed on NATCEP lockout status, or has a NATCEP approval withdrawal will be notified by Medicaid that its interim reimbursement NATCEP add-on amount will be deleted from the reimbursement rate. The nursing facility must submit a completed interim reimbursement request identifying expected NATCEP allowable costs, in

accordance with policy provisions referenced above, for consideration of an interim reimbursement add-on amount for allowable NATCEP costs incurred during the lockout period.

A nursing facility is eligible to submit an interim reimbursement request for a change in the interim payment rate add-on amount in the following situations:

- The nursing facility is experiencing a change in its current year NATCEP cost level that would cause an per diem increase or decrease in excess of $.25 per day in the current period reimbursement rate add-on.
- The nursing facility does not have previous year cost history of NATCEP cost.
- The nursing facility has been identified a lockout facility for NATCEP or CEP, or has loss of approval of its NATCEP, and has made acceptable arrangements for securing approved nurse aide training for nursing facility staff.

The nursing facility must submit a completed Nurse Aide Training and Testing Program Interim Reimbursement Request (Form MSA-1324) identifying the estimated costs to be incurred in providing approved NATCEP training for the nursing facility staff and projected resident census data. The request must be submitted to RARSS and must include the signed certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) Electronic copy of the request form and completion instructions can be accessed on the MDCH website. (Refer to the Directory Appendix for website information.)

The submitted data is subject to review and adjustment by Medicaid for consideration and calculation of the interim rate add-on payment to the facility. Medicaid will issue the provider a rate notice indicating the accepted cost level for interim rate determination, or a request denial and reason for such action. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.12 Special Circumstances – Rate Determination

10.12.A. New Facility and Provider

A new facility is a provider operating a nursing facility where there is not Medicaid historical cost. Examples include:

- A newly constructed facility.
- An existing facility that has never before participated in Medicaid.
- A facility that has participated in Medicaid in a different Provider class.
- An existing nursing facility that has not provided nursing care for Medicaid beneficiaries or billed Medicaid in the past 2 years (24 months).

10.12.A.1 New Provider Nursing Facility Per Resident Day Plant Cost

A new provider in the Medicaid program is eligible for the Plant Cost Certification process to reflect the facility asset costs and related plant costs. The Plant Cost Certification data submission will be used for calculation of the nursing facility Plant Cost Component as outlined in the policy for the respective nursing facility class. Refer to the Plant Cost Certification and Plant Cost Component sections of this chapter for additional information.

10.12.A.2 New Provider Nursing Facility Variable Cost Component

The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in "Variable Cost Component" subsection of this chapter.

A new provider that purchases an existing facility participating in the Medicaid program or a provider with an existing, participating facility that makes major additions, renovations, or new construction does not qualify for these special methods because there are historical variable costs on which to base rates. The Variable Rate Base will be determined in accordance with Medicaid policy identified in applicable subsections of this chapter.

10.12.B. Memorandums of Understanding (MOU) – Special Agreements for Complex Care

The Nursing Facilities Coverages and Limitations Chapter, Memorandums of Understanding (MOU) – Special Agreements for Complex Care section provides for program reimbursement for nursing facilities for providing specialized care beyond services covered by the usual Medicaid per diem rate. The payment rate for specially placed residents is a negotiated prospective rate per resident day. The rate is determined for a specified period of time, not to exceed 90 calendar days without review.

Reimbursement is made for prior authorized services/care to residents who have specialized and concentrated nursing and support service needs and who have been transferred from an acute care hospital setting to an approved skilled nursing facility. The negotiated rate provides reimbursement adequate to meet the unusual needs of this type of resident in a less costly and more appropriate environment than an acute care hospital setting.

Factors used in Medicaid's negotiation of the per resident day prospective rate include, but are not limited to, complexity, type of equipment and supplies required, the resident's condition, and the market place availability of placement. Any authorized increase in the per diem rate represents only the cost of the service. The negotiated

prospective rate is re-evaluated, in consideration of the resident's needs, prior to the last day of the approval period.

10.12.C. Hospice Owned/Operated Nursing Facility

Nursing Facilities Coverages and Limitations Chapter, Hospice Services section outlines the program policy regarding nursing facility beneficiaries eligible for hospice care services and reimbursement to the hospice care provider for room and board for beneficiaries in Medicaid or Medicaid/Medicare certified beds. The individual nursing facility per diem rate is determined in accordance with program policy outlined in this chapter, if the nursing facility operation is not a hospice owned/operated licensed nursing facility.

Reimbursement for daily room and board for hospice beneficiaries in a hospice owned/operated licensed nursing facility is also available to the hospice care provider. The program does not require annual cost reporting and does not determine individual nursing facility per diem rates for the hospice owned/operated licensed nursing facility due to the unique licensure requirements applicable to these nursing facilities. The program utilizes alternative cost data elements to calculate a nursing facility per diem rate that is specifically applicable to hospice owned/operated licensed nursing facilities. This per diem rate determination is the basis for setting the hospice owned nursing facility rate used for reimbursing the room and board services that will be billed to the program by the hospice provider for hospice beneficiaries cared for in its licensed nursing facility. The hospice provider will be responsible for billing the room and board services and will be reimbursed 95% of this "hospice nursing facility" rate.

The hospice owned nursing facility rate is made up of four components: plant cost component, variable cost component, economic inflationary update and quality assurance supplement. The rate calculation method for the hospice owned nursing facility rate will be in accordance with the rate determination process established for Class I nursing facility. Alternative data will be utilized for the cost data elements normally applicable to the specific nursing facility. The data elements for the rate calculation will be:

Plant costs:

Nursing Facility Current Asset Value (CAV) – Class I nursing facility CAV upper bed limit for the respective rate year time period

Nursing Facility Tenure Factor – equal to 12 years for a rate of return on CAV (.0525)

Resident Days – equals 310 (represents 85% minimum occupancy level per bed)

Variable costs:

Variable Rate Base (VRB) – Class I nursing facility Class Average of Variable Costs (AVC) for the respective rate year time period

Economic Inflation Rate (EIR):

Equal to legislative appropriated annual economic inflation percentage for Class I nursing facilities.

Quality Assurance Supplement (QAS):

QAS per diem amount – equal to the lesser of the variable rate base or Class I nursing facility variable cost limit times the Quality Assurance Assessment Factor (QAAF) determined by the Department for the respective rate year time period

Hospice Owned/Operated Nursing Facility rates are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

10.12.D. Hospital Leave Day

Nursing Facilities Coverages and Limitations Chapter, Hospital Leave Days section identifies the parameters for program reimbursement.

Reimbursement for a hospital leave day is a single rate paid to all nursing facility providers regardless of facility class. The rate is determined annually with an effective time period coinciding with the State fiscal year. The rate determination utilizes the Class I nursing facility Class Average Variable Cost (AVC) for the State fiscal year. The hospital leave day reimbursement rate represents a calculated salary and wage component of the room and board cost portion of the total AVC. The room and board portion is equal to 95 percent of the Class I nursing facility AVC, and the salary and wage component is determined as 66 percent of the room and board cost. The formula for calculating the hospital leave day rate is:

AVC (Class I NF)	X	95% (room and board portion)	X	66% (salary and wage component)	=	**Hospital Leave Day Rate**

Hospital Leave Day rate information is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

10.12.E. Therapeutic Leave Day

Nursing Facilities Coveages and Limitations Chapter, Therapeutic Leave Days section identifies the parameters for program reimbursement.

The reimbursement rate for a therapeutic leave day is the nursing facility's established per diem rate in effect for the period coinciding with the leave day.

10.12.F. One Day Stay

Nursing Facilities Coverages and Limitations, One-Day Stay section identifies the parameters for program reimbursement.

The reimbursement rate for an approved one-day stay is the nursing facility's established per diem rate in effect for the period coinciding with the stay.

10.12.G. Out of State Nursing Facility (Nonenrolled Michigan and Borderland Providers)

Medicaid Provider Manual, General Information Chapter, All Provider, Nonenrolled Michigan and Borderland Providers and Beyond Borderland Area sections provide for reimbursement of nursing care services to out of state nursing facilities. The out of state nursing facility must comply with provisions outlined in the manual. There is no cost reporting or reimbursement settlement activity for out of state nursing facilities.

The routine nursing care per diem rate for the out of state nursing facility is the lesser of the individual Provider's home state Medicaid rate or the Michigan Medicaid out of state provider ceiling rate. The ceiling rate is effective for the time period coinciding with the State fiscal year rate period October 1 through September 30. The ceiling rate is the sum of three components: 1) Class I nursing facility Variable Cost Limit (VCL) for the corresponding rate year, 2) Economic Inflationary Update, and 3) most recent Plant Cost 80th percentile per diem amount. Out of State nursing facility rates do not participate in the Quality Assurance Assessment program.

The out of state nursing facility must submit a copy of the nursing facility's home state Medicaid program reimbursement rate to the RARSS to be assigned a reimbursement rate. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) Out of state nursing facility rate assignments will only be effective on a prospective basis for the first day of the month following receipt of the rate request by that office. The out of state nursing facility will be issued a written notice of the rate determination action. The reimbursement rate request and rate assignment for an individual nursing facility is limited to once per calendar quarter.

10.13 Rate Relief for Class I Nursing Facilities

Medicaid reimbursement rate relief for current and new nursing facility providers is determined on a case-by-case basis in accordance with specific criteria for evaluating eligibility for relief and rate methodology for determining the rate level. The following definitions of nursing facility providers are applied in this rate relief policy for Class I nursing facilities:

- Current provider is defined as the provider that operated the facility during the time period of the last cost report on which the normal rate setting would occur, and will operate the facility during the time period for which rate relief is requested.
- New provider is defined as a person or business entity that has purchased or is purchasing a nursing facility that had immediate prior Medicaid participation and the new provider ownership individual(s) or business entity are not related through family or business ties to the ownership individual(s) or business entity of the previous provider. A nursing facility sale between family members may be approved by Medicaid and the new owner may be considered a new provider under certain circumstances, as outlined in the Ownership Changes and Medicaid Termination section of this chapter.

10.13.A. Eligibility Criteria

The provider must be a Class I nursing facility:

- The provider must demonstrate that the current Medicaid payment rate (Rate + QAS) does not provide adequate funding to deliver a level of care to Medicaid beneficiaries in the facility that assures "each resident attains and maintains the highest practicable physical, mental, and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.
- The nursing facility Variable Rate Base amount must meet the following criteria:
  - For a Current Provider – The facility's Variable Rate Base is at or below the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested.
  - For a New Provider in a Medicaid-enrolled nursing facility –The facility's current Variable Rate Base is at or less than 80 percent of the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. A new New Provider facility with a Variable Rate Base between 80 and 100% of the corresponding Class Average Variable Cost is eligible for accelerated rebasing and is treated as a current provider.
- A current Medicaid provider agreement for the facility is in effect. The rate relief period is applied to the facility, and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period does not end the agreement for rate relief under this policy as long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.
- The nursing facility provider must also meet at least one of the following five criteria:
  - The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per resident day for each of the two years prior to the first year of rate relief. This comparison to cost is a measurement to normal reimbursement rate calculation methodology and excludes the effect of Executive Order reimbursement actions. The provider must submit the per diem cost analysis using the outlined format presented in the Forms Appendix titled **Form to Establish Criteria for Nursing Facility Class I Rate Relief.** The required cost analysis information is available in electronic file format on the MDCH web site.
  - The provider is required, as a result of a survey by the State Survey Agency (SSA), to correct one or more substandard quality of care deficiencies to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the requirement(s).
  - The provider has experienced a significant change in the level of care needed for current Medicaid residents in the nursing facility. Significant change is defined as an

increase of 10 minutes per day as demonstrated by MDS data. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. Minimum Data Set (MDS) data must be used for this comparison. The data is subject to a clinical review by Medicaid. The analysis must also include a comparison of the previous and current nurse staffing levels required and other nursing related costs or requirements likely to increase the operational costs. This does not include nursing administration staff.

- The provider is new in a Medicaid-enrolled facility and the facility's most recent cost report submitted to Medicaid was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting includes non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors or their designees in accordance with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate.
- Rate relief is needed to prevent closure of a Medicaid-enrolled facility due to a regulatory action by the SSA, where the facility's closure would result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider would operate the facility at its current reimbursement rate. A facility would meet this hardship criteria only if a new owner has agreed to take over its operation and it is either the only nursing facility in the county or the facility has at least 65% percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county.

10.13.B. Rate Relief Petition Process

All petitions for rate relief must be in writing and submitted to RARSS. An authorized representative from the entity that holds the nursing facility license must sign the petition.

Medicaid will make the final determination for the approval or disapproval of the rate relief request. Medicaid will provide a written response within 60 days of Medicaid's receipt of the rate relief request. The response may a request for additional information. The 60 day time period does not begin until the Provider has submitted all of the necessary documentation for Medicaid to evaluate the rate relief request. Once the nursing facility provider has complied with the request(s) for additional information, a written notice of the approval or disapproval is given within 30 days of Medicaid's receipt of the additional information.

If Medicaid requests additional or supporting documentation needed to complete the evaluation of the rate relief request, the Provider must submit the documentation within 30 days of the request. If Medicaid does not receive the documentation or the Provider has not received a one-time extension for 30 additional days, the SMA will issue a denial notice for rate relief. Appropriate time allowances will be made in cases where the needed data is for time period that is not yet concluded. Subsequent rate relief request by the Provider will only be effective on a prospective basis following receipt of the new request and documentation for rate relief.

10.13.C. Rate Relief Agreement

If the rate relief petition is approved, Medicaid will prepare a rate relief agreement to be signed by the nursing facility authorized representative and an authorized representative of Medicaid. Once the agreement is approved, the provider's Medicaid rate is adjusted consistent with the relief granted. The agreement outlines the rate relief granted, the effective date and any conditions or requirements.

Requirements may include but are not limited to:

- Annual and interim cost reporting requirements during the period of rate relief.
- Appointment of a monitor, at facility cost, for oversight if, after consultation with staff in the SSA, such action is deemed appropriate.
- Follow-up surveys by the SSA.

10.13.D. Rate Relief Period

Rate relief is effective on a prospective basis beginning in the month after receipt of the request by RARSS. No retroactive rate relief will be approved.

Nursing facility providers may apply and receive rate relief under this policy once every seven years, i.e., 84 months. This seven-year period begins on the effective date of rate relief.

Example: If rate relief takes effect January 1, 2003, the facility would not be eligible for rate relief again until on or after January 1, 2010.

The rate relief period is based on the facility, not on the owner or licensee. A change of ownership does not void the seven-year period under this policy.

10.13.E. Withdrawal of Rate Relief Agreement

Medicaid may withdraw the rate relief agreement if the facility is cited by the SSA for serious certification violations while receiving rate relief. If the citation(s) is for serious and immediate threat or substandard quality of care; or the provider not spending the money in accordance to the plan filed for special rate relief the rate relief agreement may be withdrawn. Medicaid will review the nursing facility actions to determine if rate relief termination is warranted. If Medicaid terminates the agreement is by, the nursing facility's Medicaid rate will be recalculated in accordance with existing Medicaid reimbursement policy without rate relief. The rate change would take effect at the beginning of the month following issuance of a 30-day notice to the provider.

10.13.F. Rate Relief Appeals

Nursing facility providers that receive notices of denial for rate relief or are notified that a rate relief agreement has been withdrawn may file an appeal. Appeals are handled in accordance with the existing appeals process. Additional information appears in the Appeal Process Section in this chapter.

10.13.G. Rate Relief for a New Provider in a Medicaid-Enrolled Nursing Facility with a Variable Rate Base less than or Equal to 80% of the Class Average Variable Cost

A new provider in a Medicaid enrolled nursing facility with a Variable Rate Base less than or equal to 80 percent of the Class Average Variable Cost may request an increase in the current facility rate. The new provider must be operating in a facility that has previously participated with Medicaid.

10.13.G.1 Rate Relief Methodology

A new rate is calculated using the Class I Average Variable Cost for the appropriate year as the Variable Rate Base for the calculation of the facility Variable Cost Component, thereby increasing the facility per diem rate. This Variable Rate Base is in effect through the current State fiscal year rate period ending September 30.

Effective October 1 of the State fiscal year rate period starting after the new provider begins operation, the Variable Rate Base is determined using accelerated rebasing. The accelerated rebasing utilizes the new provider's first cost reporting period that reflects at least 7 months of nursing facility operation. The cost reporting time period is based on the new provider's established fiscal year. The nursing facility allowable variable cost is indexed to October 1 of the year that is one year prior to the new rate year being calculated, by applying the appropriate cost index. The new provider Variable Rate Base is limited to the Class I Average Variable Cost for the corresponding rate year time period.

The new provider receiving rate relief in this category must file a **Class I Rate Relief Interim Cost Statement** prior to September 15. The Interim Cost Statement (Medicaid cost reporting formats identified below) must reflect actual or expected costs incurred by the nursing facility for the new provider's first cost reporting period (as referenced above). The facility's annual cost report may be used in lieu of the Interim Cost Statement if the cost report will be filed with Medicaid prior to September 15.

The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the MDCH required electronic format:

- Checklist
- Worksheet A
- Worksheet B
- Worksheet 1
- Worksheet 1-C (only if claiming allocated related party costs)
- Worksheet 2

The Interim Cost Statement is used to determine the interim rate utilizing the accelerated rebasing provisions. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

The subsequent rate year calculation is in accordance with standard reimbursement methodology.

Example: A new nursing facility provider begins operations on January 1, 2004, selects a September 30 year-end cost reporting period. Following request, the provider is approved for rate relief for rate year October 1, 2003 to September 30, 2004. The facility per diem rate is set using the Class I Average Variable Costs effective for the rate year beginning October 1, 2003 (effective for the new provider on January 1, 2004). The provider must complete an interim cost statement for variable costs for the period January 1, 2004 through September 30, 2004, that must be filed by September 15, 2004. Effective October 1, 2004 the Variable Rate Base is the lesser of the variable costs from the interim cost statement, indexed to October 1, 2003 OR the Class Average Variable Cost effective October 1, 2004. Following the filing of the annual cost report, the variable costs from the annual report are indexed to October 1, 2003 and the interim Variable Rate Base is recalculated.

Rate relief is subject to audit and settlement with reimbursement adjustment using the principles and guidelines outlined in Medicaid policy. Rate relief reimbursement cannot exceed the appropriate cost and rate limitations. The provider is reimbursed by Medicaid for any underpayment, and the provider must reimburse Medicaid for any overpayment. If the interim Variable Rate Base determined for rate relief reimbursement to the provider exceeds the audited Variable Rate Base reimbursement by more than 3%, the provider will be assessed a penalty equal to 10% of the total overpayment amount.

A nursing facility provider receiving rate relief is allowed to participate in any other add-on reimbursement programs at their election. These programs are handled under the Medicaid policy applicable to the program. The costs associated with these add-on programs are not included in the cost settlement of the variable costs for rate relief as previously described.

10.13.G.2 Rate Relief Documentation

It is the provider's responsibility to present supporting documentation with the rate relief petition. Petition from a new provider must include:

- Identification of the criteria under which relief is requested.
- Supporting documentation for the criteria.
- Detail the circumstances causing the need for the rate relief request.
- The proposed effective date. The actual effective date of the rate relief is based on the date the petition is received by Medicaid. The earliest effective date would be the first day of the next month following the receipt of the request.
- The services time period that is the basis for which rate relief is requested.
- Specific details reflecting how the additional funds will be spent (i.e. staffing, consultants, medical supplies, etc.).
- Plans on how these changes will ensure the required level of resident care.

10.13.H. Rate Relief for a Current Provider or a New Provider in a Medicaid Enrolled Nursing Facility with a Variable Rate Base between 80% and 100% of the Class Average Variable Cost

A current or new provider in a Medicaid enrolled nursing facility with a Variable Rate Base between 80% and 100% of the Class Average Variable Cost may request accelerated rebasing.

Rate relief applies only to the nursing facility's Variable Rate Base. The facility's qualification for adjustment of the Plant Cost Component in the Medicaid rate and Nurse Aide Training and Testing costs is handled in accordance with current Medicaid policy.

10.13.H.1 Rate Relief Methodology

Accelerated rebasing is the use of the Medicaid cost report data from the period ending in the current calendar year in the rate setting process, rather than using cost report data from the period ending in the previous calendar year under the standard reimbursement methodology. The nursing facility's allowable variable cost is indexed to October 1 of the year that is one year prior to the rate year being calculated, by applying the appropriate cost index.

Example: The provider's cost report for the period ending December 31, 2003 could be used to set the October 1, 2003 rate if approved for rate relief under this policy. The provider would be allowed to participate in any add-on reimbursement programs at their election.

The cost reporting is based on the provider's established fiscal year, and must not cover a time period of less than 7 months. The cost report period used for accelerated rebasing must have a reporting period end date prior to January 1 of the State rate year.

Example: A cost report time period ending after January 1, 2004 could not be used for accelerated rebasing of a rate effective during the State rate year October 1, 2003 through September 30, 2004.

10.13.H.2 Rate Relief Documentation

It is the provider's responsibility to submit supporting documentation with the rate relief petition. Petition from the provider must include:

- Identification of the criteria under which rate relief is requested.
- Supporting documentation for the criteria.
- Detail of the circumstances causing the need for the rate relief request.
- A requested effective date (the actual effective date of the rate relief is based on the date that the petition is received by Medicaid). The earliest effective date would be the first day of the next month. For example, a petition received on August 31 may be effective as soon as September 1.
- The services time period that is the basis for which rate relief is requested.

- Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care.
- Plans on how these changes will ensure the required level of resident care.

SECTION 11 - APPEAL PROCESS

A nursing facility participating in the Medicaid program may appeal an adverse action and certain determinations made by Medicaid. The provider will be given a written notice of the determination or action that outlines the proposed action, the provider's appeal rights, and the appeal process.

Adverse actions include, but are not limited to:

- A suspension or termination of a provider's Medicaid program participation;
- A reduction, suspension, or adjustment of provider payments;
- A retroactive adjustment following an audit or review of a facility's daily reimbursement rate or other services reimbursement.
- The prospective reimbursement rate determination.

Some elements of the Medicaid nursing facility reimbursement determination methodology are not appealed e through an administrative process, but may be appealed to a court of appropriate jurisdiction. These are elements, where an administrative remedy, if permitted for a single provider, would imply or necessitate a change for all providers or for all providers in a class, and include, but are not limited to:

- The formula for the determination of the nursing facility cost factor.
- The Principles of Reimbursement and guidelines that define allowable costs.
- Medicaid Interim Payment (MIP) Program normal payment amount or reconciliation of payments and approved service billings.
- Non-Medicaid issues.
- Cost limits established in program policy.
- Medicaid's determination of allowable items and costs until an audit has been completed.

The review and hearings process for providers has been promulgated in the administrative rules and is explained in MDCH's Administrative Hearings Manual located on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

11.1 AUDIT APPEALS

Each nursing facility cost report is audited to ensure that expenses attributable to allowable cost were reported in adherence with Medicaid policy. Once the audit report is completed a Preliminary Summary of Audit Adjustments Notice. This notice outlines audit results and advises the provider of their appeal rights, including the right to an Area Office Conference.

If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments within 15 days of the date of the Notice, the provider will receive a Final Summary of Audit Adjustment Notice. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with DCH rules for hearings.

If a provider wants an Area Office Conference, the provider or the provider's designee must send a written request to the audit representative(s) within 15 days of the Preliminary Summary of Audit Adjustments Notice date. The Area Office Conference is a forum for the provider or their designees to present documents and arguments contesting the Preliminary Summary of Audit Adjustments Notice. The audit representative(s) must schedule an Area Office Conference within 15 days of the receipt of the provider's or provider designee's request. Within 15 calendar days after the Area Office Conference, the audit representative(s) must issue a Final Summary of Audit Adjustments Notice to the provider. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with DCH rules for hearings.

If a provider does not appeal or does not respond to the Final Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review.

11.2 Rate Appeals

Providers are notified in writing of their Medicaid reimbursement rate(s) at least 30 days prior to the rate's effective date. The provider is given an opportunity for informal review of the rate determination by RARSS. The provider also may formally appeal issues of disagreement or dispute regarding the determined reimbursement rate. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Medicaid Reimbursement.

11.3 Reimbursement Settlement Appeals

A final settlement reimbursement determination is made to determine the aggregate Medicaid reimbursement to the nursing facility for the time period covered by the cost report. Providers are notified in writing of the final reimbursement settlement and given an opportunity for informal review of the settlement determination. The provider may formally appeal issues of disagreement or dispute of the reimbursement settlement determination. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Program Reimbursement.

11.4 Provisional Rates

A provider will be given a provisional rate for the new rate year if:

- Medicaid is responsible for a delay in determination procedures.
- An Area Office Conference or Administration Conference is in progress.
- The potential for an Area Office Conference or an Administrative Conference is still open at the beginning of the rate year that begins a year and a day after the end of the rate year that is being processed.

For this purpose, "delay in the procedures" means (if applicable):

- Medicaid failed to issue the Preliminary Summary of Audit Adjustments in a timely manner.
- Medicaid failed to conduct the Area Office Conference in a timely manner.

- Medicaid failed to issue the Final Summary of Audit Adjustments Notice, including a final determination notice, in a timely manner.

11.5 Provider Payment Adjustment Resulting From Appeal Decision

If the appeal result requires a change in a provider's rate or reimbursement level, the change will be made retroactively for service time periods coinciding with the effective dates of the original reimbursement rate notice. Payment adjustments will be made by an aggregate adjustment rather than by individual claim adjustments.

SECTION 12 MEDICAID INTERIM PAYMENT PROGRAM

A Nursing facility has the option of selecting one of two payment methods: Payment directly related to claims submitted to and processed by the Invoice Processing system or enrollment in the Medicaid Interim Payment Program (MIP).

Providers enrolled in MIP receive a pre-determined dollar amount in cycled payments. MIP payments represent the expected dollar amount that Medicaid would have paid to the nursing facility in claims reimbursement during a period of time. The MIP payment calculation is based on historical approved billings, current reimbursement rate and claims data. The Department may perform interim reconciliation(s) if a significant amount is due the program. After the end of the quarter, a comparison is made of the most recent pre-determined payment and the approved days activity billed. The result of the comparison could result in an increase or a decrease to the MIP payment amount. A reconciliation is done at the end of the provider's fiscal year.

12.1 ENROLLMENT IN MIP

To participate in MIP, a Medicaid participating provider must submit a written request to RARSS. New providers complete New Provider Information Data form (LTC-20A). Established providers may submit a written request. Providers must acknowledge and agree to the terms of participation in the MIP as outlined in this section. Requests to enroll in MIP must be received one month prior to the beginning of the calendar quarter for which enrollment is desired.

If enrollment is approved, RARSS will enroll the provider in MIP in the calendar quarter following the approval of RARSS. Once MIP payments begin, claims approved through the Claims Processing system regardless of date of service will not generate a separate or additional payment.

12.2 DISENROLLMENT IN MIP

To disenroll in MIP, the provider must submit a written request to RARSS. The request to disenroll must be received by RARSS one month prior to the end of a calendar quarter. Disenrollment is effective at the beginning of the calendar quarter following the receipt of the request by RARSS.

Providers terminating participation in the Medicaid Program will not receive a MIP payment in the final month of participation.

The final month's MIP payment is subjected to reconciliation to determine the status of MIP. Special arrangements may be made where there is guaranteed assurance the State can recover any payment difference that may exist as the result of MIP participation. A Provider interested in a special arrangement must contact RARSS for consideration.

Providers interested in re-enrollment in the MIP program must wait at least one full quarter before reapplying.

12.3 Claims Submission

Providers are expected to submit claims for services rendered in a timely manner. Although a provider enrolled in MIP does not receive payment directly from claims submission, future MIP payments are affected by claims submission. MIP payments are calculated for expected days to be reimbursed.

12.4 Calculation of MIP Payment

The MIP amount is recalculated on a quarterly basis. The recalculation is to update the MIP amount to reflect the current Medicaid billing activity for the facility and the provider's Medicaid per diem rate when necessary. A recalculation may occur any time during a calendar quarter due to a change in the provider's per diem rate. The quarterly recalculation is based on the approved claims activity over the most recent twelve months, regardless of the date of service, and Medicaid utilization during the same time period. At the end of each quarter, the recently completed quarter's approved claims are used to update the MIP payment calculation.

The annually projected State liability to the provider (total reimbursement less other insurance and patient payments) will be divided by 24 to determine the regularly scheduled payment amount that will be made twice a month. The other insurance and patient payment amounts are based on the most recent quarter payment data projected to an annual amount.

In the case of major problems to Medicaid data system where a significant change has occurred in the approved claims data for a quarter as a result of Medicaid data system, the MIP amount would continue as previously calculated or the provider may request that RARSS perform a recalculation. If a significant reduction in the MIP amount is due to a problem outside the provider's control, such as a payment system error, the provider may request that RARSS perform a recalculation as a special consideration. RARSS staff will analyze and review the request to determine if special consideration is warranted.

Interim recalculations requests as a result of provider delays in billing must be submitted to RARSS for approval or denial. Providers that have demonstrated repeated occurrences of delays in billing may not receive an interim recalculation.

12.5 Frequency of MIP Payment

The biweekly MIP payment is an estimate of one-half of the Medicaid liability for reimbursable services rendered in the previous month. The MIP payment will be paid on the first and third Wednesday of each month. This means a provider could receive 100 per cent of the monthly payment as early as the 15th day of the month and no later than the 21st day. Providers enrolled in MIP will receive 6 regularly scheduled payments during a calendar quarter.

12.6 Annual Reconciliation

The reconciliation of approved claims and MIP payments is done annually generally 90 days after the end of the Provider's fiscal year. If a provider changes their cost- reporting fiscal year, they must notify RARSS in advance in writing. Any change in a fiscal year could adversely affect a provider in the reconciliation.

If an underpayment has been made, the provider will receive a gross adjustment payment. If an overpayment is determined, recovery will be made by gross adjustment recovery against future

payments. The gross adjustment process follows the Initial and Final Settlement practices in the Settlement section of this chapter. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must provide adequate justification for the need for extended repayment.

MIP amount determination, reconciliation and adjustments are not subject to appeal under the administrative rules. The MIP Program does not determine the reimbursement rate; it is an interim payment mechanism substituting for Claims Processing payments. The provider is given advance notice of the MIP actions and can request a review with RARSS. The provider's action must be timely and specific to the problem.

12. 7 NEW PROVIDERS

New providers, resulting from a change in facility ownership, may request MIP at the time of Medicaid Program enrollment by submitting the New Provider Information Data (LTC-20A) to RARSS.

New providers, in facilities, without historical Medicaid Program billing data are not eligible for MIP.

Nursing Facilities Reimbursement Appendix

Appraisal Guidelines

Where historical cost records of a purchased asset are not available or are incomplete, or where fair market value or current reproduction cost must be established, a timely appraisal of the historical costs, fair market value, or depreciated reproduction cost (as appropriate) of the asset made by an independent, recognized expert is acceptable for depreciation and owner's equity capital purposes. The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal must be conducted in accordance with "The Principles of Appraisal Practices and Code of Ethics" of the American Society of Appraisers.

For Medicaid program purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value, or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

Appraisal Date – The date selected for establishing the value of fixed assets. For example, if December 31, 2002 was established as the appraisal date and the actual physical inventory of fixed assets was taken on February 1, 2003, any additions or dispositions of fixed assets between December 31, 2002 and February 1, 2003 must be taken into account in the appraisal values.

Appraised Book Value – The book value of an asset's appraised cost as of the date of acquisition less accumulated depreciation computed on an approved basis up to the appraisal date.

Appraisal Expert – An individual or firm that is experienced and specialized in multi-purpose appraisals of plant assets involving the establishment or reconstruction of the historical cost, fair market value, or current reproduction cost of such assets. The appraisal expert must employ a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; be experienced in appraisals of plant assets used by providers; and demonstrate a knowledge and understanding of the regulations involving reimbursement principles, particularly those pertinent to depreciation.

Approval

Medicaid does not require the nursing facility representatives to get prior approval before an appraisal is made for Medicaid purposes. Medicaid requirements are that the appraisal be conducted in accordance with the provisions of these guidelines. Questions regarding the appraisal of the nursing facility should be directed to the SMA's LTC Reimbursement and Rate Setting Section. The provider must make the appraisal agreement and final report available to Agency staff for audit review. The scope of the appraisal must conform to Medicare Principles of Reimbursement as modified by Michigan Medicaid for provider costs in effect on the appraisal date.

Need for Appraisal

An appraisal for Medicaid purposes should be made only where the nursing facility provider has no historical cost records, or has incomplete records of the depreciable fixed assets, or needs to determine an asset's fair market value or depreciated reproduction cost. The appraisal should develop the historical cost and related information that will assist in the construction, reconstruction, or revision of accounting records to enable the provider to make proper distribution of depreciation expense in cost reports. Normally, a proprietary provider will not need a historical cost basis of its assets. Where an appraisal is being performed to determine the current reproduction of an asset, the appraisal should represent the cost to reproduce the actual facility in like kind and should not be inflated by such factors as current or anticipated space needs or different construction types, e.g., masonry versus wood frame. Appraisals must be performed within the time limit specified in the proposed agreement and not on a piecemeal or intermittent basis.

Purchase of Ongoing Facility

In establishing the historical cost of assets, where an ongoing nursing facility is purchased through a bona fide sale after July 1, 1966 and prior to August 1, 1970, the purchase price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale. For depreciable assets acquired after July 1970, the cost basis of the depreciable assets must not exceed the lower of the current reproduction cost adjusted for straight-line depreciation over the life of the assets to the time of the sale or the fair market value of the tangible assets purchased.

If the nursing facility was participating in the Medicaid program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new facility owner (the purchaser) in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is limited to the lower of current reproduction cost (adjusted for straight-line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price. The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to resident care), in accordance with the fair market value of each asset as it was used by the seller at the time of sale. If the purchaser and seller cannot agree on an allocation of sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the Agency will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal. In any case, the sale price must be allocated among all the assets sold, even if some of the assets will be disposed of shortly after the sale.

If a purchaser cannot demonstrate that the sale is bona fide, the seller's net book value will be used by the purchaser as the basis for depreciation of the asset. In such case, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the Medicaid program, and these must be considered as incurred by the purchaser for Medicaid purposes.

The cost basis for the depreciable assets of a nursing facility purchased in a bona fide sale on or after August 1, 1970 is limited to the lowest of the following:

- The total price paid for the facility by the purchaser as allocated to the individual assets;
- The total fair market value of the facility at the time of the sale as allocated to the individual assets;
- The combined fair market value of the individually identified assets at the time of the sale; or
- The current reproduction costs of the depreciable assets, depreciated on a straight-line basis over the life of the assets to the time of the sale.

The purchaser has the burden of proving that the transaction was a bona fide sale, and if the burden is not met, the cost basis may also not exceed the seller's cost basis less accumulated depreciation.

Fixed Assets Included in Appraised Values

Fixed asset values established by an appraisal must include all plant assets owned by the nursing facility provider that are used in resident care or in the overall operation and administration of the facility. Fixed assets used in research and other non-allowable cost areas or functions should be included so that depreciation is reflected in those departmental costs to provide a proper basis for allocating administrative and general expense. Fixed assets of a related organization not used by a provider in rendering resident care, assets acquired in anticipation of expansion, and assets held for investment and not used in the plant operation should not be included as a part of the appraised values.

Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset values established by the appraisal. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not betterment or improvement but an expense of that period.

The pricing of assets to establish historical costs is based on such actual supporting documents as vendor invoices and construction contractor completion statements. In the absence of invoices, such other records as revenue stamps, board minutes, contracts of purchase, and deeds recorded with the county's Recorder of Deeds may be used.

Other methods, such as manufacturer's catalogs, libraries of material prices, or techniques involving reverse trending and price indices may be used to establish acquisition costs and dates. Such methods may be used only when actual supporting documents are not available. When these sources and techniques are used, consideration must be given to the manufacturers and to quantity discounts. The determined value should closely approximate the actual historical cost of an asset at the date of acquisition.

Minor Equipment

Where minor equipment is concerned, the SMA recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the nursing facility provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicaid will only recognize an appropriate amount for minor equipment costs where the original equipment acquisition cost was recorded in the accounting records as capital asset cost and had not previously recorded the minor equipment acquisition as current period operations expense..

Minor equipment includes but is not limited to such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets. The general characteristics of this type of equipment are as follows:

- The equipment is in no fixed location and is subject to use by various departments in the nursing facility;
- The items are comparatively small in size and unit cost;
- The equipment is subject to inventory control;
- There is a fairly large quantity of the items in use; and
- The equipment has a useful life of approximately 3 years or less.

However, where all other depreciable assets are concerned, such as buildings, building equipment, major movable equipment, land improvements, and leasehold improvements, the Medicaid program will not recognize a historical cost of such assets in excess of the historical cost used for federal income tax purposes. Nursing facility providers should be able to support this historical cost by reference to original documents such as contracts, vouchers, checks and other evidence. If the provider does not have such original documentation constituting primary evidence of the historical cost of assets, the Agency will consider the provider's federal income tax returns as secondary evidence to be used in establishing and verifying the historical cost of the assets. Further, it is possible that because of the effects of other provisions within the Medicare Principles of Reimbursement, such as "cost to related organizations," the historical cost under Medicaid might be less than that allowed and used for income tax purposes.

Under the Principles, nursing facility providers may change the useful lives of assets where this can be justified and appropriately adjust the accumulated depreciation applicable to the historical cost of the assets involved. The effect of such adjustments is to change the undepreciated amount of the historical cost for Medicaid purposes. The Principles do not permit providers to increase the historical cost basis of their assets to recognize elements of costs or expenditures that were not capitalized but were considered as expense items.

Examples: If a provider determines that a physical modification of the building was a repair, and thus an item of expense not capitalized, and uses the historical cost so determined for federal income tax purposes, the provider may not change the historical cost basis to include that expenditure previously determined a repair and capitalize it, i.e., increase the historical cost basis of the building for Medicaid purposes.

If a provider builds a facility and in establishing the historical cost of the building determines that material and labor used were not part of the historical cost of the

building and charges the cost of such material and labor into expenses for federal income tax purposes, the provider may not then include such expenditures in the historical cost of the building for Medicaid purposes.

Costs in excess of the cost basis used for federal income tax purposes will not be recognized under Medicaid. Further, for cost reporting periods beginning on or after January 1, 1970, the Agency will also require a redetermination of allowable costs for the reporting period covered to reflect the effects of the adjustment in the historical cost basis of the assets. For cost reporting periods beginning before January 1, 1970, however, no redetermination of such allowable costs need be made for the reporting periods covered. Accumulated depreciation applicable to the depreciable assets under the Medicaid program will include the full amount allowed during those periods in which an increased historical cost basis was used. The net book value will be used for computations of gain or loss on the sale of assets and for any other reimbursement purposes under Medicaid.

Donated Assets

The fair market value for a donated asset is the price that the asset would bring by bona fide bargaining between well-informed purchasers and sellers at the date of acquisition. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

Exception: In cases where an asset has been used or depreciated under the Medicaid program and then donated to a provider, the basis of depreciation will be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program.

If the nursing facility provider's records do not include the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

Where material, labor, and services are donated in the construction of an asset, the asset value is the sum of the appraised cost of the material, labor, or services actually donated and the incurred cost of that part which was not donated. Labor costs should be determined in accordance with both the rates prevailing in the community at the time of construction and the type of labor incurred, i.e., if the labor donated was non-union labor, the cost would be at the non-union labor rate rather than at a union labor rate. If records are not available as to the actual labor, services, or material donated, the fair market value at the time of donation may be determined by the other methods shown in Medicare Principles of Reimbursement. Estimated labor costs provided by an owner or shareholder of a facility are not includable in the historical cost of constructed assets.

Assets Costing less than $100

Individual major movable assets costing less than $100, whether or not purchased in quantity prior to the appraisal date, may be capitalized at the time of appraisal at the purchase cost less accumulated depreciation from the date of acquisition regardless of the provider's past accounting practices. If an election is made to capitalize such assets, this policy must be applied consistently.

Nursing facility providers that have expensed such items while in the Medicaid program may not decide later to capitalize them. This also applies to those providers that eventually decide to have appraisals. The appraisal expert may group major movable equipment with a unit cost of $100 or less. However, the book value assigned to such grouped assets at appraisal may not exceed the book value of the assets if individually appraised. Identification of the individual assets comprising the group must be available.

Tagging of Equipment

For Medicaid program purposes, tagging of equipment is not mandatory. In the absence of tagging, however, alternate records must be maintained to satisfy audit verification of the existence and location of the assets.

Appraisal Programs

Since the condition of nursing facility provider asset records varies significantly, an appraisal program may be comprehensive or partial. For instance, a provider may engage an appraisal expert to appraise a part of its facility for which no historical records have been maintained, or a provider may need to have an appraisal made on a particular class of assets in a specific identified location.

Comprehensive appraisal programs are usually appropriate because of such complexities as lump-sum purchases of assets or a complete lack of historical cost records for all assets.

An appraisal program should include:

- A physical inventory and listing of pertinent data for all applicable assets in use or in standby status as of the appraisal date or report date. The physical inventory may be made by the provider or by the appraiser. If made by the provider, the appraiser must verify the inventory.
- The acquisition cost of each item or unit of property including but not limited to architect fees, installation costs, and freight.
- A classification of each item or unit of property in accordance with the American Hospital Association (AHA) Health Data and Coding Standards Group, Estimated Useful Lives of Depreciable Hospital Assets. These classifications are:
    - Land improvements;
    - Buildings, including building improvement, fixed equipment, building services equipment and other fixed equipment;
    - Major movable equipment;
    - Minor equipment; and
    - Leasehold equipment.

    Note: Refer to the Cost Classifications and Cost Finding section of this chapter for a comprehensive description for capital assets by category.

- Establishing an estimated useful life for each asset. The estimated useful life for purposes of the appraisal must be consistent with the estimated useful life for each asset used by the provider for depreciation purposes.
- Determining a salvage value for each asset.
- Selecting a depreciation method for each asset.

- Calculating depreciation provisions for the current reporting period.
- Calculating accumulated depreciation, using an approved basis, from the date of acquisition to the start of the Medicaid reporting period in which actual depreciation is first claimed.
- Determining square footage for each cost center to identify all rooms on a floor or within a building if the provider did not previously do this. This should be accomplished as explained in the AHA Cost Finding and Rate Setting for Hospitals.
- Reconciling appraisal results with provider records. For assets acquired prior to January 1, 1966, the provider's plant asset records, if any, and accounting records must be considered even though they may be inaccurate. This reconciliation must be made for land improvements, buildings, building services equipment, and where possible for other major asset classifications.
    - Where applicable, differences discussed by the reconciliation must be reflected as adjustments in the provider' accounting and plant asset records.

Appraisal Report

The appraisal expert must prepare a letter of certification. The letter should state that, in the appraisal expert's judgment, the appraisal results were determined in conformity with Medicaid program regulations and requirements. This letter will include such information as:

- Name of the nursing facility provider for which the appraisal was conducted;
- Location(s) of the facility included in the appraisal;
- Appraisal date, the date up to which accumulated depreciation was calculated (if other than the appraisal date), and the period for which current depreciation is calculated;
- Contents of data supplied to the provider, i.e., summaries, schedules, plans, etc.;
- Appraisal program descriptions, including:
    - The extent of asset appraisal, i.e., assets physically inventoried,
    - Pricing basis, and
    - Other pertinent information not readily apparent in the detail results, such as depreciation methods.
- Policy for determining capitalizable assets;
- Depreciation policy in the year of acquisition and disposal; and
- Identification of material items included in the appraisal where the values of such items were obtained from outside sources without independent verification by the appraisal expert.

Listing of Assets Appraised

If a listing of assets that constitutes the nursing facility provider's Medicaid property records is supplied, it must contain all necessary and pertinent information, even if portions were determined solely by the provider. A listing of assets should include the following information for each asset:

- Building location;
- Cost center or department;
- Asset description, usually including manufacturer's name, model number, serial number, etc.
- AHA asset classification;
- Historical cost;

- Acquisition date;
- Estimated useful life to provider;
- Salvage value;
- Depreciation provision for current reporting period;
- Accumulated depreciation provision for current reporting period; and
- Pricing method necessary for adequate disclosure, where more than one method was used for various assets.

Reconciliations and comparisons with provider records must also be included, as well as square footage and other allocation basis information for buildings and cost centers within buildings.

Records

Appraisal work papers must be made available to SMA SMA staff or their designees upon reasonable request.

Appraisal Expense

The expense of an appraisal to establish plant records for Medicaid program purposes, including the expense for appraisal of research and other non-resident departments, incurred by a nursing facility provider after entrance into the program, may be included as an allowable cost. The expenses will be considered as administrative costs in the period incurred, subject to apportionment to the Medicaid program. Appraisal expenses incurred relative to assets not connected with provider operations are not allowable costs.

Where providers have appraisals made for other business purposes, such as insurance coverage, tax values or financing, the incurred expenses for such appraisals may be included in allowable costs as part of administrative and general costs. However, appraisal expenses incurred to establish values for the sale or anticipated sale of the nursing facility or provider organization are not allowable costs.

Where the SMA determines that a provider has incurred appraisal expenses to establish the historical cost of assets, which were already adequately reflected in its books, records, or tax returns, the cost of performing the appraisal is not allowable.

Nursing Facilities Reimbursement Appendix

Cost Reporting and Reimbursement Descriptions and Classifications

General

Refer to Cost Classification and Cost Finding section of this chapter for detailed discussion and description of Program cost categories for Plant, Variable Base, Support and Base/Support.

Plant 1 – depreciation cost category generally allocated to operational cost centers on the basis of square footage.
Plant 2 – depreciation cost category generally allocated to operational cost centers on the basis of square footage or asset dollar value.
Plant 3 – interest, real and personal property taxes, allowable lease rental and borrowing-related amortization cost category generally allocated to operational cost centers on the basis of square footage.

PLANT COSTS

RENT/LEASES

Leases	Plant 1
Underlying Cost – Depreciation	Plant 1
Underlying Cost – Interest	Plant 3
Underlying Cost – Property Taxes	Plant 3
Lease Rental Component	Plant 3
Other Non-allowable Costs	Support
Interests – Mortgage & Bond	Plant 3
Interest – Other	Plant 3
Interest – Paid to Owner(s)	Plant 3
Amortization – Interest Related	Plant 3
Property Taxes	Plant 3
Depreciation – Building & Improvements (fixed)	Plant 1
Depreciation – Equipment (moveable)	Plant 2
Depreciation – Vehicles	Plant 2

EMPLOYEE HEALTH & WELFARE

FICA – Employer's Portion	Base/Support
Federal Unemployment Tax	Base/Support
MESC	Base
Workers Compensation	Base/Support
Pension & Profit Sharing	Base/Support
Employees Group Insurance	Base/Support
Retirement	Base/Support
Other	Base/Support

ADMINISTRATIVE & GENERAL

Salaries & Wages – Officers	Support
Salaries & Wages – Administrator	Support
Salaries & Wages – Owner/Administrator	Support
Salaries & Wages – Clerical & Other	Support
Employee Benefits	Support

Workers Compensation	Base
Payroll Taxes	Support
Director's Fees	Support
Management Services	Support
Central Office Overhead	Support
Contracted Services	Support
In-service Training	Support
Education	Support
Advertising	Support
Promotion & Public Relations	Support
Telephone & Other Communications	Support
Dues & Subscriptions	Support
Insurance - Officer's Life	Support
Insurance – General	Support
Malpractice Liability Insurance	Support
Copier	Support
License Fees	Support
Quality Assurance Assessment	Support
Transportation	Support
Equipment Repair & Maintenance	Support
Vehicles	Support
Office Supplies	Support
Printing	Support
Postage, UPS, Freight	Support
Legal & Accounting	Support
Utilization Review	Support
Income Taxes	Support
Other Taxes	Support
General Travel	Support
Travel & Seminars	Support
Data Processing	Support
Amortization – Non-interest Related	Support
Employment Agency Fees	Support
Charitable Contributions	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Security Guard Services	Support
Penalties	Support
Miscellaneous	Support
Bad Debt	Support

PLANT OPERATION AND MAINTENANCE

Salaries & Wages – Plant Operation & Maintenance	Support
Employee Benefits	Support
Workers Compensation	Base
Payroll Taxes	Support
Contracted Services	Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support

Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Deprecation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Repair & Maintenance – Building	Support
Repair & Maintenance – Equipment	Support
Repair & Maintenance – Grounds	Support
Building Insurance	Support
Supplies	Support
Miscellaneous	Support
Trash Removal	Support
Snow Removal	Support

UTILITIES

Gas & Fuel	Base
Electricity	Base
Water	Base
Miscellaneous	Base

LAUNDRY

Salaries & Wages – Laundry	Base
Employee Benefits	Base
Workers Compensation	Base
Payroll Taxes	Base
Contracted Services – Base	Base
Contracted Services – Support	Support
Contracted Services – Base/Support	Base/Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest 7 Property Taxes	Plant 3
Repair & Maintenance	Support
Linen & Bedding	Base
Laundry Supplies	Base
Miscellaneous – Base	Base
Miscellaneous – Support	Support

HOUSEKEEPING

Salaries & Wages – Housekeeping	Support
Employee Benefits	Support
Workers Compensation	Base
Payroll Taxes	Support
Contracted Services	Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support

Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Housekeeping Supplies ..... Support
Miscellaneous ..... Support

DIETARY

Salaries & Wages – Dietary ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services-Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Raw Food ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

NURSING ADMINISTRATION

Salaries & Wages – Director of Nursing ..... Base
Salaries & Wages – Other ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Office Supplies ..... Support
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services –Base/Support ..... Base/Support
In-service Training ..... Support
Salaries & Wages – In-service Training ..... Support
Employee Benefits – In-service Training ..... Support
Payroll Taxes – In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3

Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

CENTRAL SUPPLIES

Salaries & Wages – Central Supplies ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous ..... Support

MEDICAL SUPPLIES

Salaries & Wages – Medical Supplies ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Base
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous ..... Support

MEDICAL RECORDS & LIBRARY

Salaries & Wages – Medical Director ..... Support
Salaries & Wages – Medical Records ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Support
Contracted Services – Medical Director ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support

Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous ..... Support

SOCIAL SERVICES

Salaries & Wages – Social Services ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Supplies ..... Support
Contracted Services – Base ..... Base
Contracted Services - Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

DIVERSIONAL THERAPY

Salaries & Wages –Divers ional Therapy ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Supplies ..... Base
Contracted Services – Base ..... Base
Contracted Services - Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

ANCILLARY SERVICE COST CENTERS

RADIOLOGY

Salaries & Wages – Radiology ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

LABORATORY

Salaries & Wages – Laboratory ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

INTRAVENOUS THERAPY

Salaries & Wages – Intravenous Therapy ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

INHALATION THERAPY (OXYGEN)

Salaries & Wages – Inhalation Therapy ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Oxygen – Intermittent Use ..... Base
Oxygen – Continuous Use ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2

Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3

PHYSICAL THERAPY

Salaries & Wages – Physical Therapy ..... Support
Employee Benefits ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Payroll Taxes ..... Support
Contracted Outside Services ..... Support
Other ..... Support

SPEECH THERAPY

Salaries & Wages – Speech Therapy ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

OCCUPATIONAL THERAPY

Salaries & Wages – Occupational Therapy ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

ELECTROENCEPHALOGRAPHY

Salaries & Wages – Electroencephalography ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Electroencephalography ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental - More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3

PHARMACY

Salaries & Wages – Pharmacy ..... Support
Employee Benefits - Pharmacy ..... Support
Payroll Taxes - Pharmacy ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Pharmacy - Other ..... Support
Drugs – Legend ..... Base
Drugs – Non-Legend ..... Support
Special Services ..... Support

PHYSICIAN SERVICES

Salaries & Wages – Physician Services ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

NURSING SERVICE COST CENTERS

MEDICARE SNF UNIT

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base

Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

MEDICAID ROUTINE CARE UNIT #1

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

MEDICAID ROUTINE CARE UNIT #2

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3

Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

MEDICAID SPECIAL CARE UNIT #1

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

MEDICAID SPECIAL CARE UNIT #2

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

HOME FOR AGED UNIT

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base

In-service Training..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation..... Plant 1
Direct Allocation – Equipment Depreciation..... Plant 2
Direct Allocation – Interest Property Taxes..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support..... Support

NON-LTC APARTMENT/HOUSING UNIT

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services..... Base
In-service Training..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation..... Plant 1
Direct Allocation – Equipment Depreciation..... Plant 2
Direct Allocation – Interest Property Taxes..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support..... Support

NON-MEDICARE AND NON-MEDICAID LICENSED ONLY

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services..... Base
In-service Training..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation..... Plant 1
Direct Allocation – Equipment Depreciation..... Plant 2
Direct Allocation – Interest Property Taxes..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support..... Support

NON-LTC NURSING SERVICES

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

REIMBURSABLE/NON-REIMBURSABLE COST CENTERS

NON-AVAILABLE BEDS

Medicaid Non-Available Beds ..... Non-Reimbursable

NURSE AIDE TRAINING & TESTING - LTC ..... Pass-Through

SPECIAL DIETARY

Salaries & Wages – Special Dietary ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Depreciation ..... Plant 1
Direct Allocation – Equipment Depreciation ..... Plant 2
Direct Allocation – Interest 7 Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Raw Food ..... Base
Dietary Supplies (Non-Ingested) ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

BEAUTY & BARBER SHOP

Beauty & Barber Shop Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

GIFT, FLOWER, COFFEE SHOP & CANTEEN

Gift, Flower, Coffee Shop & Canteen Salaries..... Non-Reimbursable
Other ..... Non-Reimbursable

PHYSICIAN'S PRIVATE OFFICE

Physician's Private Office Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

NON-PAID WORKERS

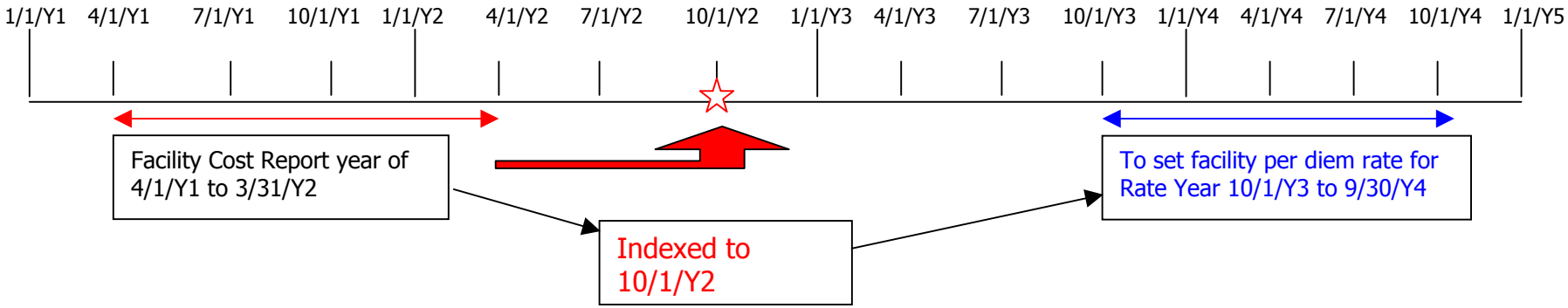
Non-Paid Workers Salaries..... Non-Reimbursable
Other ..... Non-Reimbursable

OTHER

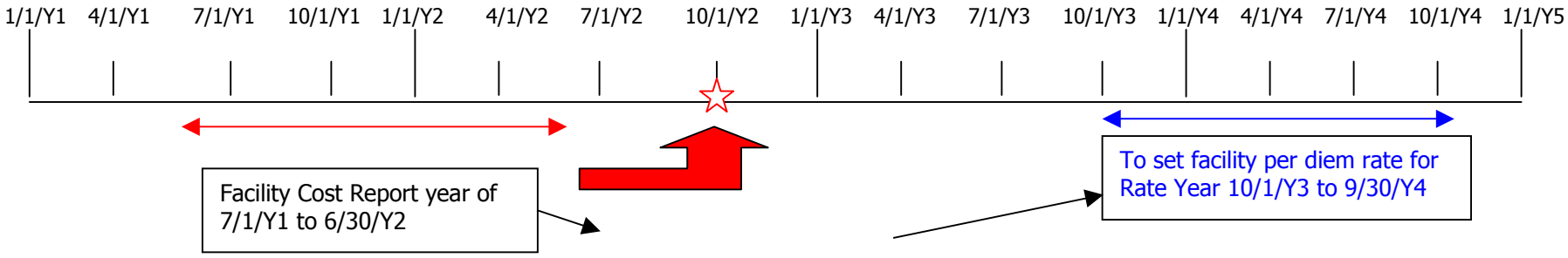
Other Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

Nursing Facilities Reimbursement Appendix
Timeline and Rate Setting Process

Timeline for Per Diem Rate Setting Process for Nursing Facilities with Cost Reporting Year from April 1 through March 31

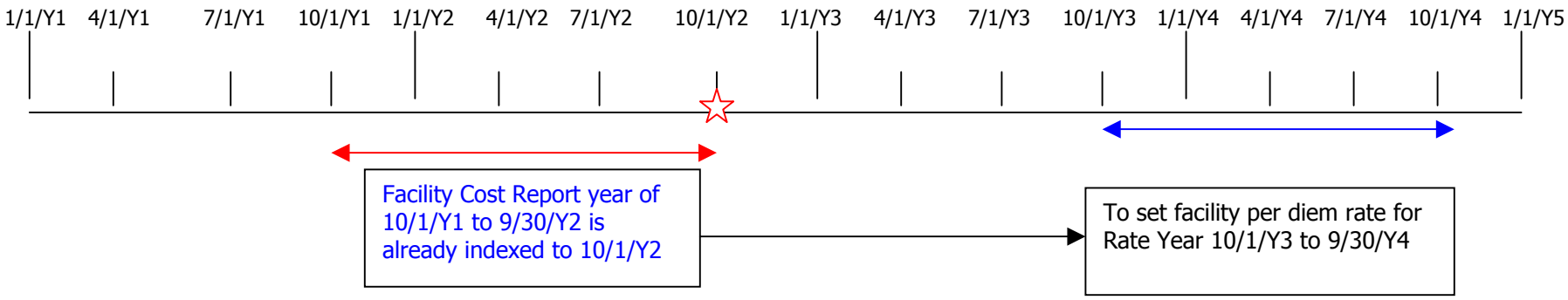


Timeline for Per Diem Rate Setting Process for Nursing Facilities with Cost Reporting Year from July 1 through June 30

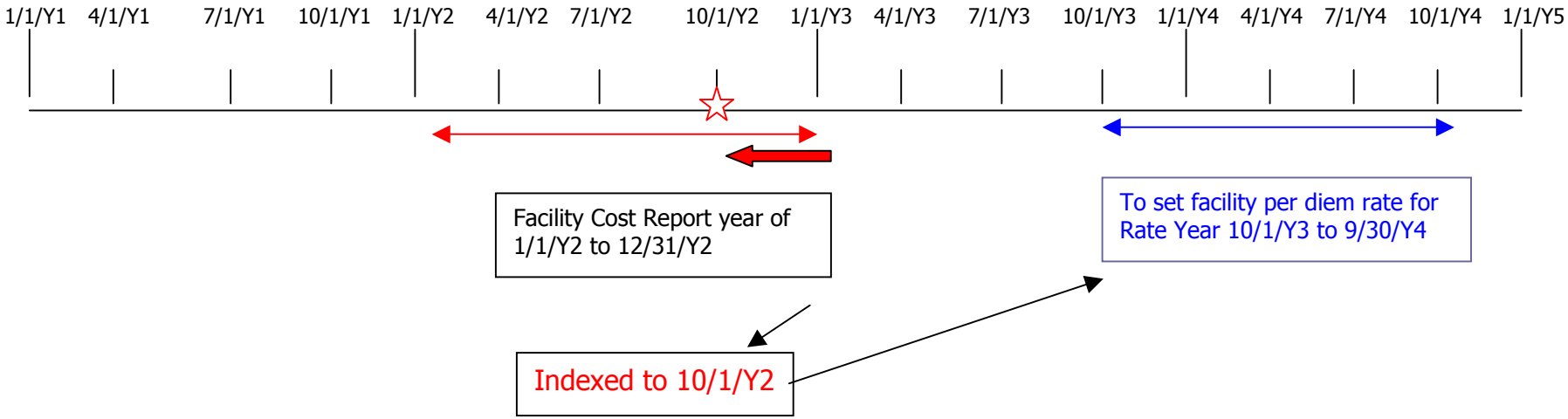


Indexed to 10/1/Y2

Timeline for Nursing Facility Per Diem Rate Setting Process for Facilities with Cost Reporting Year October 1 through September 30



Timeline for Nursing Facility Per Diem Rate Setting Process for Facilities with Cost Reporting Years from January 1 though December 31



Nursing Facilities Reimbursement Appendix

Timeline and Rate Setting Process

Calculation of Medicaid Reimbursement Rate

Class I-Provider Type 60

Date:	9/1/03
Provider Name:	Sample Nursing Facility #1
Provider Number:	60-1111111
F.Y.E:	December 31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

Total Beds: 120
Medicaid-certified LTC Beds: 100

A.	Variable cost per day	Filed Period End: 12/31/02		102.632807
B.	Base cost per day			76.092223
C.	Support cost per day			26.540584
D.	Provider's support/base ratio			0.348795
E.	Support/Base ratio limit per bed size group			0.340100
F.	Cost Index (CI)	From: 12/31/2002	To: 10/01/2002	0.992754
G.	Indexed base cost component (BCC) (base cost per day times CI)			75.540859
H.	Indexed support cost component (SCC) (lesser of Provider's S/B ratio or S/B limit times indexed base cost)			25.691446
I.	Variable Rate Base (VRB) (base cost component plus support cost component)			101.232305
J.	Variable Cost Limit (VCL)	As of: 10/01/2003		123.750000
K.	Lesser of Variable Rate Base or Variable Cost Limit			101.232305

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		101.232305
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not part of rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	101.232305
B.	Quality Assurance Assessment Factor (QAAF)	21.76%
C.	Quality Assurance Supplement	22.02815

Nursing Facilities Reimbursement Appendix

Timeline and Rate Setting Process

Calculation of Medicaid Reimbursement Rate

Class I-Provider Type 60

IV. Property Tax/Interest Expense/Lease Component

Filed Period End: 6/30/02

	Total Days:	17,761
	Plant Costs:	58,431
A. Allowable borrowings limitation		
1) Average borrowings balance		496,600
2) Interest deduction for excess borrowings		0
3) DEFRA sales disallowance		0
4) Net property tax/ interest/ lease component		58,431
B. Per patient day plant component		**3.289849**

V. Return On Current Asset Value Component

Tenure: 20

A.	Updated Building and Land Improvements	1,736,925
B.	Depreciated Moveable Equipment	95,691
C.	Land	51,996
D.	Total current asset value	1,884,612
E.	Percentage applicable to LTC unit	100.00%
F.	LTC unit current asset value x percent	1,884,612
G.	Current Asset Value upper (ceiling) limitation	2,193,000
H.	Current Asset Value lower (floor) limitation	657,900
I.	Tenure factor	0.0525
J.	Limitation or asset value x tenure factor	98,942
K.	**Limitation or asset value x tenure factor/patient days**	**5.570753**

Rate Calculation

Prospective Reimbursement

A.	Lesser of Variable Rate Base of Variable Cost Limit	101.232305
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A Plus Line B)	101.232305
D.	Plant Cost Component	8.860602
E.	Reimbursement Rate Prior to Add-Ons	**110.0929**

OBRA Training & Testing Cost Settled

Period End: 6/30/02 W/S 8 Costs: **Filed** 5,644 **0.317775**

Special Dietary

Medicaid Reimbursement Rate **110.4107**

Nursing Facilities Reimbursement Appendix

Timeline and Rate Setting Process

Calculation of Medicaid Reimbursement Rate

Class III-Publicly Owned-Provider Type 61

Date:	9/1/03
Provider Name:	Sample Medical Care Facility
Provider Number:	61-6666666
F.Y.E:	December31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

		Total Beds:	204
		Medicaid-certified LTC Beds:	204
A.	Variable cost per day	Filed Period End: 12/31/02	145.079291
B.	Base cost per day		114.513735
C.	Support cost per day		30.565556
D.	Provider's support/base ratio		0.266916
E.	Support/Base ratio limit per bed size group		0.329600
F.	Cost Index (CI)	From: 12/31/2002 To: 10/01/2002	0.992754
G.	Indexed base cost component (BCC) (base cost per day times CI)		113.683968
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		30.344078
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		144.028046
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	169.280000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**		**144.028046**

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		144.028046
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

Nursing Facilities Reimbursement Appendix

Timeline and Rate Setting Process

Calculation of Medicaid Reimbursement Rate

Class III-Publicly Owned-Provider Type 61

III. Calculation of Plant Cost Component

Filed Period End: 12/31/02

A.	Depreciation and Interest Expenses	359,738
B.	Total Days	73,098
C.	Plant Costs per Day	4.921311
D.	Plant Cost Limit	5.410000
E.	**Lesser of Plant Cost or Plant Cost Limit**	4.921311

Rate Calculation
Prospective Reimbursement

A.	Lesser of Variable Rate Base or Variable Cost Limit	144.028046
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A plus Line B)	144.028046
D.	Plant Cost Component	4.921311
E.	Reimbursement Prior to Add-Ons	148.949357

OBRA Training and Testing Cost Settlement

Period End:	12/31/01	W/S 8 Costs: Filed	24,026	.328682

Medicaid Reimbursement Rate 149.278039

Nursing Facilities Reimbursement Appendix

Timeline and Rate Setting Process

Calculation of Medicaid Reimbursement Rate

Class III-Non-Publicly Owned-Provider Type 62

Date:	9/1/03
Provider Name:	Sample Hospital LTC Unit
Provider Number:	62-7777777
F.Y.E:	June 30
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

		Total Beds:	48
		Medicaid-certified LTC Beds:	40
A.	Variable cost per day	Filed Period End: 6/30/02	201.403421
B.	Base cost per day		152.625018
C.	Support cost per day		57.778403
D.	Provider's support/base ratio		0.378564
E.	Support/Base ratio limit per bed size group		0.378600
F.	Cost Index (CI)	From: 6/30/2002 To: 10/01/2002	1.007353
G.	Indexed base cost component (BCC) (base cost per day times CI)		153.747270
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		58.203248
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		211.950518
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	169.280000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**		**169.280000**

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		169.280000
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	169.280000
B.	Quality Assurance Assessment Factor (QAAF)	21.76%
C.	Quality Assurance Supplement (QAS)	36.835328

Nursing Facilities Reimbursement Appendix

Timeline and Rate Setting Process

Calculation of Medicaid Reimbursement Rate

Class III-Non-Publicly Owned-Provider Type 62

IV. Calculation of Plant Cost Component

Filed Period End: 6/30/02

A.	Depreciation and Interest Expenses	75,221
B.	Total Days	14,030
C.	Plant Costs per Day	5.361440
D.	Plant Cost Limit	5.410000
E.	**Lesser of Plant Cost or Plant Cost Limit**	**5.361440**

Rate Calculation
Prospective Reimbursement

A.	Lesser of Variable Rate Base or Variable Cost Limit	169.280000
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A plus Line B)	169.280000
D.	Plant Cost Component	5.361440
E.	Reimbursement Prior to Add-Ons	**174.64144**

OBRA Training and Testing Cost Settlement

Period End: 6/30/02	W/S 8 Costs: Filed		12,000	.800000

Medicaid Reimbursement Rate **175.4414**

Michigan Department of Community Health

Nurse Aide Training and Competency Evaluation Program

Certified Nurse Assistant Training Reimbursement

PURPOSE: The Certified Nurse Assistant (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Birthdate _____ Driver License/Identification _____

I incurred the following expenses to become a CNA (Certified Nurse Assistant).

TRAINING: *(Attach receipts)*

Approved Program Name: _____ Amount $ _____

Location _____ Date of Payment: _____

Completion Date of Training: _____

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Knowledge Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Rescheduling Fee (No-Show)

Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Initial Registration Fee Date: _____ Amount: $ _____

Registration Document Renewal Date: _____ Amount: $ _____

Check appropriate box, sign and date*:*

☐ **I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.**

☐ **I have received payment from another source for the listed expenses:**

Amount: $ _____ Date: _____ Source: _____

Amount: $ _____ Date: _____ Source: _____

Amount: $ _____ Date: _____ Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider I.D. Number: _____ MDCH License Number: _____

